THE GENDER BASED VIOLENCE INDICATORS STUDY

BOTSWANA



The Women's Affairs Department (WAD) is a department within the Ministry of Labour and Home Affairs. The mandate of WAD includes facilitating the process of creating positive change through sensitisation of development agents on gender and development issues. In line with this, the Department provides guidance and leadership on gender and development to partners including Government Ministries and Departments, Parastatal organisations, the Private Sector and Non-governmental Organisations. WAD exists to create a gender sensitive environment, conducive for the promotion of equality between women and men in Botswana.

Gender Links (GL) is a Southern African NGO that is committed to a region in which women and men are able to participate equally in all aspects of public and private life in accordance with the provisions of the Southern African Development Community (SADC) Protocol on Gender and Development. GL achieves its vision by coordinating the work of the Southern African Gender Protocol Alliance formed around the sub-regional instrument that brings together all key African and global commitments for achieving gender equality. Working with partners at local, national, regional and international level, GL aims to:

- Promote gender equality in and through the media and in all areas of governance.
- Develop policies and conduct effective campaigns for ending gender violence, HIV and AIDS.
- Build the capacity of women and men to engage critically in democratic processes that advance equality and justice

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Foreword



Botswana's Vision 2016, through its pillar "A Safe and Secure Nation" commits to the elimination of the violation of physical well-being and human rights of individuals. The country's Constitution guarantees everyone equality before the law (Sections 3 and 15).

Botswana subscribes to the Millennium Development Goals, which for this particular context include the Promotion of Gender Equality and the Empowerment of Women (Goal 3), and to the Southern African Development Community (SADC) goal of halving gender violence by 2015.

The Gender Based Violence (GBV) Indicators Botswana study provides shocking statistics on the prevalence of gender based violence in the country. Almost 70% of the women interviewed had experienced GBV at least once in their lifetime. Nearly 30% experienced violence over the last year. We can extrapolate that more than 200 000 women had their rights violated at the very moment that we are working towards attaining human rights for all.

I would like to commend the Botswana Police Service for the sterling job being undertaken by Gender Focal Points to improve GBV data collection, cited in this report as an international best practice. Equally worthy of accolades is progressive work in the area of administration of justice regarding successful prosecution of reported and upheld cases.

However, one of the most shocking statistics in this report is that the prevalence rate, as established through the first ever GBV prevalence and attitude survey, *is 24 times higher than the number of cases reported to the Police over the last year!* Successful conviction rate of GBV cases viewed against this overall figure is less than one percent (1%) of GBV experienced.

Clearly, there is a crisis of confidence. Women are not engaging and so not enjoying the full benefit of the very systems that are supposed to offer them redress.

As the former Police Commissioner and Acting Minister of Defence, Justice and Security, I am deeply saddened by these findings. Through these government structures and in collaboration with other equally committed development focussed partners, the Government of Botswana continues to work tirelessly to ensure that citizens and residents of Botswana are safe and secure. These research findings are a wakeup call for all to realise that the GBV challenge looms much larger than individual and isolated stand alone efforts of conventional institutions with custodial responsibility for safety from GBV. It takes a community to root out GBV.

This report is unique in its multi-sector and multi-dimension approach. The attitude part of the survey shows that GBV in Botswana is deeply rooted in patriarchal ideologies that at best ignore, and at worst condone violence against women. The media monitoring and political content analysis show that leaders have not been making their voices heard strongly enough on this national scourge; the most serious violation of human rights in the country at the present time and the biggest threat to our achievement of Vision 2016.

The GBV Indicators Botswana Study provides a set of comprehensive data on all forms of GBV, both intimate partner violence and non-partner violence. We must use this data to inform the envisioned National Action Plan to End Gender Violence. We also need to put in

place a holistic plan and budget for effective implementation. This is consistent with the UN Secretary General's UNite to End Violence Campaign, and with various initiatives within the African Union and SADC to see real progress towards ending gender based violence by 2015.

Botswana has many pillars of strength to draw on. Apart from a democratic and responsive government, we have the experience of our bold HIV and AIDS campaign that is starting to bear fruit in reduced levels of new infections. We realised in this case that prevention should be placed at the centre of all our strategies, and not at the tail end of reactive response and support strategies. Pursuant to the national commitment to reduce the spread of HIV, successive Presidents have tasked Government Ministers with championing this campaign at every turn.

I am convinced that the enormity of the situation particularly regarding the prevalence GBV in Botswana has somewhat been obscured by lack of baseline data. Now we have a good indication, crude as it may be. We also know that among others, there is a direct correlation between GBV and the spread of HIV. So we can safely conclude that with such an alarmingly high GBV prevalence level, the spread of HIV through heterosexual relationships will remain the principal mode of transmission until the prevalence rate of GBV is arrested. In order to win the HIV and AIDS battle once and for all, deliberate and decisive measures should be taken to wage an equally fierce battle against GBV - with equal zeal and earnestness.

The political content analysis shows that only 6% of political speeches centred on GBV over the last year, with an additional 9% mentioning this human rights violation in some way. *We can do better than that! We must make it known, from every platform, pulpit, and kgotla, that we, the leaders of Botswana say no to gender violence!*

I thank Gender Links Botswana, UNDP, UNFPA and other UN agencies, plus other donors, as well as all our national partners who joined the Women's Affairs Department to bring us this report, a wakeup call indeed! The report is but the start of a longer journey we must walk together. *Bagaetsho, Bo sele bo sena mahube!* With the unflinching commitment of every individual, family, community and the nation at large, we can exterminate GBV.

Vision 2016 beckons and yes, we must position ourselves for positive results now!



Honourable Edwin Jenamiso Batshu
Minister of Labour and Home Affairs

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Acknowledgements

The *Gender Based Violence Indicators Study* is a Southern African research project aimed at measuring and monitoring the extent, effect, cost of, and efforts to end violence against women. The study, piloted in South Africa, Mauritius, and Botswana, takes place against the backdrop of the Southern African Development Community (SADC) Protocol on Gender and Development that aims to halve levels of gender violence by 2015.

The Women's Affairs Department (WAD) in the Ministry of Labour and Home Affairs partnered with Gender Links (GL) to conduct the study in Botswana in 2011. WAD managed and provided resources for the logistic aspects of the prevalence and attitudes survey and for the research assistants. GL provided the study methodology; training for the research assistants, the personal digital assistants (PDAs); data analysis and quality assurance as well as the overall coordination of different aspects of the study. The partnership between a government department and NGO in conducting this study is a best practice that GL hopes to replicate in other SADC countries.

GL and WAD express their sincere appreciation to the 1229 women and men who participated in this study. We are especially indebted to the 25 women and 10 men who shared their personal testimonies or "I" stories and agreed to have them published in this research. To protect their identity and to avoid any further suffering, the editors have referred to those who gave first hand accounts using pseudonyms that they chose. Special thanks to Women Against Rape, Selebi Phikwe Town Council and Chobe District Council for their assistance in collecting the *"I" Stories*. The voices of those most affected give this study power and urgency.

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The Ministry of Health assisted in securing the required research permit and ethical clearance for the study. Women in Law Southern Africa (WLSA) Botswana gathered and analysed the administrative data for this report. Godisang Mookodi, Senior Lecturer and former Head of the Department of Sociology at the University of Botswana coordinated the political content analysis data.

We would like to thank all stakeholders in this research for their guidance and assistance with accessing and contributing valuable information and statistics. These include the Botswana Police Service, Ministry of Health, Courts, Department of Social Services, the Attorney General's Chambers, Department of Public Prosecutions, Kagisano Society Women's Shelter (KSWSP), Molepolole Drop-In Centre, Stepping Stones International, Women Against Rape, Lifeline and the local councils.

WAD Director Valencia Mogegeh and GL CEO Colleen Lowe Morna provided the overall strategic management and oversight of the study. GL Chief of Operations Kubi Rama, GL GBV Indicators Research Manager Mercilene Machisa and WAD Coordinator for UN funded programmes Kelly Dambuza managed the research project in Botswana. Marinda Weideman, on behalf of GL, co-managed the prevalence and attitudes survey with Dambuza. Game Makondo Principal Gender Officer and Head of the Research Division, together with Shepherd Monyeki and Dorcas Sefudi Babini (both gender officers at WAD) and Kabelo Mompati Tsiang, an Intern Officer in WAD, assisted in the implementation of the project.

Keabonye Ntsabane, GL Botswana Office Coordinator managed partnerships and stakeholder relationships for the project. She also conducted the *"I" Stories* research.

Tichakunda Tsedu, GL research intern, analysed the political discourse data and wrote the media case studies for his report. Oarabile Monggae, intern at the GL Botswana office, collected case studies for this report.

Ninety-three research assistants visited households, recruited participants and administered survey questionnaires in the nine districts of Botswana over three weeks. These included: Kealeboga Setlhotlhane, Kelebogile Joshua, Gaolatlhelelwe Gaolatlhwe, Ketlhobogile Yatwe, Thandi Oageng, Eric Lobopo Marumoagae, Letebele Sosome, Albert Makhwaje, Tshenolo Lotshawo, Phillip Oabona, Boineelo Chelenyane, Tefo Mmereki, Onkabetse Kitso, Paul Rammala ,Mbabi Bapabi, Pretty Kgotso Kelebetseng, Golekanye Bunnert Ranthoyakgale, Boitumelo Disang, Meleko Sekhungu, Kebone Mothibakgomo, Maipelo Semmee, Omphile Toto, Abel Makondo, Kemmonye Mbwe, Mothusi Chabaya, Ofentse Raseipone, Aaron Seipato, Oduetse Morebodi, Thatayotlhe Fanabe, Ndiko Motshusi, Lulu Ngakane, Molefi Juta, Emmanuel Lesope, Letlhogonolo Bolokwe, Onalenna Dichaba, Lindie Bogosi, Refilwe Kehupetse, Veronica Mbaha, Michael Ramakatane, Olefhile Rantalajwe, Thabiso Ookame, Precious Kula, Tebogo Mangole, Mokganedi Mosimanewamotho, Cyril Mbeha Nzamo, Lebole Dikgang, Bokamoso Diseko, Kutlo Lesetedi, Mmabatho Dikgang, Etisani Nganunu, Abednico Matobo, Boingotlo Sedigeng,Gaamangwe Nfila, Keamogetswe Yvonne Modise, Alex M. Moepedi, Nancy Motekwane, Thatayaone Molemoeng, Gosiame Joseph, Boitumelo Gabontshwe, Gosegojang Olekantse, Matshelo Ramolapong, Tshepiso Britz, Lydia Ramatu, Boago Sibanda, Tshiamo Ngake, Joyce Labobedi, Tshepiso Precious Mothudi, Baboloki Lopang, Atlogeleng Motsumi, Kamogelo Dube,Zwelani Timothy, Chengetani Batlegang, Otsetswe Maphakwane, Kabo Gaonewe, Kelebogile Marumo, Keemenao France, Letlhogonolo Dinonyane, Keletso Makhala, Maipelo Madikwe, Gotaatweng Ketlholegile, Tshenolo Nelson Molapi, David Marenga, Tampiwa Pilato, Temogo Keosentse (WAD Intern), Joseph T Pipadibe, Maipelo Molefe (WAD Intern), Babaki Sokwa, Oratile Omphile Macheng, Edward Morwe, Oarabile Monggae, Brenda Kgakgamatso (WAD Intern), Keabetswe Motswakhumo and Oreeditse Segokgo.

Machisa and Botswana Programme Officer, Roos van Dorp drafted the report. GL CEO Colleen Lowe Morna and GL Chief of Operations Kubi Rama edited the report with input from a reference group that reviewed the final draft. The reference group comprised: Anouk Malboef from the Botswana Network of People Living with HIV and AIDS (BONEPWA); Doreen Mooketsi from the Botswana Network on Ethics, Law and HIV and AIDS (BONELA); Olive D'Melho from Positive Community Impact Botswana: Tirelo Modie-Moroka from University of Botswana Social Work Department; Tumelo Molelekwa-Tebelopele ; Edwin Tumisang Pheko from Botswana Council of Churches, Gwen N Lesetedi from Women and Law Southern Africa Botswana and University of Botswana; Moemedi Tsimanyane from the Botswana Association of Local Authorities (BALA); Patricia Kole from the Botswana Media Women's Association (BOMWA); Lorato Moalosi Sakofiwa from Kagisano Women's Shelter Project; Anastacia Ramotshabi from Botswana Prisons Service; Joanna Shaddeton from Stepping Stones International; Joseph Pitso from the United Nations Population Fund (UNFPA); S. Samuel Moepeng from the Botswana Police Service; S Madikwe from Gamodubu Child Care Trust, K.Mogano from Faith Gospel After Christ; T.P Motlhagodi from the Organisation of African Instituted Churches (OAIC); G.Kesupile from Statistics Botswana; M Ramaretlwa from Statistics Botswana; Mpho Gilika from the African Women Leadership Academy (TAWLA); S.I Gabathusi from Botswana Police Service; Maude Dikobe from the University of Botswana; Obenne Phokwe from OAIC; I Mfila and V Galatlhwe.

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Kubi Rama is GL Chief of Operations. She is the former CEO of the Gender and Media Southern Africa (GEMSA) Network where she was responsible for the programme, financial and institutional development of GEMSA. In her earlier time as Deputy Director and Network Manager of Gender Links she was responsible for managing a new audience research project, coordinating the regional network, setting up a virtual resource centre for media trainers, coordination and sustaining the Sixteen Days of Activism, organising a regional media summit and mainstreaming gender as part of training curricula. Prior to joining Gender Links, Rama served at the Department of Journalism (Durban Institute of Technology) as a senior lecturer.



Kealeboga Kelly Dambuza is the Coordinator of UN funded projects under the Women's Affairs Depart-ment in the Ministry of Labour and Home Affairs in Botswana. Her role involves coordination of donor support. Dambuza has spearheaded the implementation of a various projects including GBV capacity building, implementation of GBV strategies aimed to reduce HIV and AIDS, facilitation of the establish- ment of gender focal points in the Botswana Police Service and facilitation of a GBV referral system aimed at coordinating GBV service providers in Botswana. Dambuza co-managed the training of researchers and survey fieldwork in this

study. Currently, she is coordinating the implementation of a project on women in informal cross border trade in Botswana. Previously Dambuza worked for Safe Blood for Africa Foundation as a technical advisor to the Botswana Blood Donor Programme within the National Blood Transfusion Service and to NGOs. Her role was to provide technical assistance on the involvement of young people in blood donation and HIV prevention activities. Kelly holds a Bachelor of Arts degree in Social Sciences with majors in Population Studies and Economics from the University of Botswana and is currently pursuing a Masters Degree in Public Health with the University of South Africa.



Game Makondo is the Principal Gender Officer and head of the Research Division at the Women's Affairs Department. She is currently managing the domestication of the African Gender and Development Index and is a focal person for the reporting and domestication of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) at the Women's Affairs Department. In her previous responsibility with Population Services International Botswana, she served as Head of the Research Department. She holds a Bachelor of Arts in Social Sciences (demography) from the University of Botswana and is currently studying towards a Masters degree in Population Studies with the University of Botswana.



Mercilene Tanyaradzwa Machisa is the GBV Indicators Research Manager. She managed the data on the GBV Indicators Gauteng Project and analysed the household prevalence and attitudes survey. She also contributed in implementation of the other research components and writing of this report. Prior to joining Gender Links, Machisa worked for the National Institute of Health Research in Zimbabwe as a Medical Research Officer. Her main research interest is sexual and reproductive health. She holds a BSC (Hons) degree in Biological Sciences from the Midlands State University and is currently studying towards an MSc (Med) in Epidemiology and Biostatistics degree with the University of Witwatersrand.



Keabonye Ntsabane is the Gender Links Botswana Country Manager. Her first encounter with Gender Links was in the 1990s through her work as Information Officer for the Women's NGO Coalition in Botswana. She holds vast experience in lobbying and advocacy work aimed at empowering women, including coordinating and scheduling programmes with media houses. Ntsabane is a seasoned events coordinator, and has strong networks and connections in Botswana. She is trained in Media Monitoring, which has resulted in her involvement in the Gender and Media Baseline study and the 2005 Global Media Monitoring Project. She holds a High National Diploma in Media Journalism.



Godisang Mookodi is a Senior Lecturer and former Head of the Department of Sociology at the University of Botswana. She holds a PhD in Sociology from the University of Toronto. Her experience in gender equality and women's empowerment spans over thirty years. She started her career in the then Women's Affairs Unit in the Government of Botswana. Since joining the University in 1990 she has been active in advancing gender equality at the institution through active participation in the Gender Policy and Programme Committee (GPPC), through teaching and research. She also places gender equality in the forefront of her participation in regional and local organisations such as the Organisation of Social Science Research in Southern and Eastern Africa (OSSREA) Botswana Chapter and the Botswana Network on Ethics Law and HIV and AIDS and the Young Women's Leadership Project at the University of Botswana.

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Roos van Dorp is the Programme Officer at Gender Links' satellite office in Botswana. Since 2008,van Dorp has provided support to the national programme implementation in the areas of Gender and Media, Gover-nance, and Justice and the SADC Protocol Alliance Barometer. She assisted during the prevalence study with technical assistance to the data collection and contributed to writing of this report. Prior to joining Gender Links van Dorp studied International Development Studies at the University of Amsterdam and completed an internship in Gaborone at the SADC-Development Finance Resource Centre. She holds a BA degree in Communications from the Amsterdam University of Applied Sciences.



Shepherd Monyeki is a sociologist working as a WAD Gender Officer with a focus on gender and development research. He began his career as a research assistant at the University Of Botswana, then at Lakisama Consultancy Company before joining WAD as an Assistant Gender Officer.



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Kabelo Mompati Tsiang is an Intern Officer in WAD, UN Projects Section. He provides assistance in research projects for the department. He joined WAD in 2010 as a research assistant playing an instrumental role in the planning and coordination of a study on the Gender Based Violence Referral System.



Tichakunda Tsedu is research intern at Gender Links. He analysed the political discourse and compiled media case studies for this report. Interested in the ways in which the media can help create social change, he joined GL in 2011 and briefly worked in the Gender and Media Diversity Centre.



Oarabile Monggae is a Botswana Government intern deployed to the GL Botswana Office. He monitored Yarona FM, The Guardian and Mmegi Daily. Monggae was a research supervisor in the prevalence and attitudes survey. He also collected institutional case studies for this report.

Acronyms

AIDS	-	Acquired Immune Deficiency Syndrome
ARV	-	Anti-retroviral drugs
BALA	-	Botswana Association for Local Government
BNYC	-	Botswana National Youth Council
BPS	-	Botswana Police Service
CS	-	Court Services
CBO	-	Community Based Organisation
DV	-	Domestic violence
DVA	-	Domestic violence Act
EFB	-	Evangelical Fellowship of Botswana
GBH	-	Grievous Body Harm
GBV	-	Gender based violence
GL	-	Gender Links
GMPS	-	Gender and Media Progress Study
HIV	-	Human Immuno Deficiency Virus
IOM	-	International Organisation for migration
IPV	-	Intimate partner violence
KSWSP	-	Kagisano Society Women's Shelter
MRC	-	South African Medical Research Council
NGO	-	Non Governmental Organisation
PDA	-	Personal Digital Assistant
PEP	-	Post Exposure Prophylaxis
PSU	-	Primary Sampling Unit
NAP	-	National Action Plan to end violence against women and children
SADC	-	Southern African Development Community
STI	-	Sexually transmitted infections
SSI	-	Stepping Stones International
UN	-	United Nations
UNECA/AGS	-	United Nations Economic Commission Africa Gender Centre
UNIFEM	-	United Nations Development Fund for Women
UNFPA	-	United Nations Population Fund
VAM	-	Violence against men
VAW	-	Violence against women
VCT	-	Voluntary Counselling and testing
WAD	-	Women's Affairs Department
WAR	-	Women Against Rape
WHO	-	World Health Organisation

Executive Summary

Over two thirds of women in Botswana (67%) have experienced some form of gender violence in their lifetime including partner and non-partner violence. A smaller, but still high, proportion of men (44%) admit to perpetrating violence against women.

Nearly one third of women (29%) experienced Intimate Partner Violence (IPV) in the 12 months to the prevalence survey that formed the flagship research tool in this study. In contrast, only 1.2% of Batswana women reported cases of GBV to the police in the same period. *Thus the prevalence of GBV reported in the survey is 24 times higher than that reported to the police.* This suggests that levels of GBV are far higher than those recorded in official statistics and that women have lost faith in the very systems that should protect them as well as offer redress.



Botswana Police Services marching to promote community policing. *Photo: Vincent Galatlhwe*

Most of the violence reported occurs within intimate relationships. About three in every five women (62%) experienced violence in an intimate relationship while about half of the men (48%) admitted to perpetrating intimate partner violence. About 30% of women experienced while 22.4% of men perpetrated GBV in the 12 months before the survey. Emotional partner violence is the most common form of IPV experienced by women (45%) and perpetrated by men (37%) in the sample in their lifetime.

Similar proportions of women (11.4%) and men (10.7%) reported experiencing or perpetrating non-partner rape respectively. Despite the high levels of rape, only one in nine women report rape to the police and only one in seven women seek medical attention.

Patriarchal attitudes are a significant underlying factor driving the incidence of GBV in Botswana. While women and men affirm gender equality in the public domain this has not translated in their private lives particularly in their intimate relationships.

The findings from the survey and police data show that *GBV is the most flagrant violation of human rights in Botswana at the present time*, yet only 6% of the 188 speeches by politicians over the last year focused on GBV while 9% made some mention of the scourge. Only 5% of monitored news articles from Botswana covered GBV and in these perpetrators were three times more likely to be heard than survivors. The media still reports on GBV in sensational ways that trivialise the experiences of women.

These are among the key findings of the GBV Indicators Research project in Botswana undertaken by Gender Links (GL) and the Women's Affairs Department (WAD). These findings, which are significantly higher than those reported in a study using similar methods in

South Africa's metropolitan Gauteng province show that GBV has reached pandemic proportions in Botswana and needs to be treated with the same urgency as HIV and AIDS. As a key building block in the achievement of Vision 2016, GBV needs to be placed high on the political agenda.

Inspired by the Commonwealth Plan of Action on Gender and Development (2005-2015) and Southern African Development Community (SADC) Protocol on Gender and Development target of halving GBV by 2015, the research project provides the first comprehensive and comparative baseline assessment of the extent, effects and response to GBV in Botswana. Following similar methods to those employed in studies three provinces of South Africa (Gauteng, Western Cape and KwaZulu Natal) and Mauritius, this study employed five methods with a nationwide prevalence and attitudes survey as its flagship.

A representative sample of 639 women and 590 men across Botswana completed questionnaires in their preferred local language on behaviour and experiences related to GBV .Researchers asked women about their experience of violence perpetrated by men while men were asked about their perpetration of violence against women.

The focus on violence against women is justified by overwhelming evidence that the majority of gender violence cases consists of violence against women and these cases result in extensive and well-documented adverse health consequences (Krug et al 2002). Comparing what women say they experience to what men say they do adds credibility to the findings. The study explored both intimate partner and non-partner violence. Forms of IPV include physical, emotional, economic, and sexual.

In addition to the prevalence survey, tools used include the interrogation of administrative data from police, courts and shelters; collection of first-hand accounts of women's and men's experiences of GBV, media monitoring and political discourse analysis. Forms of non-partner violence include sexual harassment and rape.

Some of the main findings from the study are:

Extent of GBV

Table one: Extent of GBV

Criteria	Prevalence of GBV survey				Extent of reporting to police	
	Women's experience in a lifetime %	Men's perpetration in a lifetime %	Women's experience in the past year %	Men's perpetration in the past year %	Reporting in a lifetime %	Reporting in past 12 months %
Prevalence of GBV	67.3	44.4	29.0	22.4	-	-
Prevalence of intimate partner violence	62.3	47.7	28.9	22.4	-	-
Prevalence of emotional intimate partner violence	44.7	37.9	19.6	16.5	-	-
Prevalence of physical intimate partner violence	35.2	27.6	13.3	8.4	7.1	4.0
Prevalence of economic intimate partner violence	28.6	18.2	16.3	10	-	-
Prevalence of sexual intimate partner violence	14.6	7.3	5.1	5.4	-	-
Prevalence of emotional, economic, physical and sexual violence	6.1	4.4	1.8	2.7	-	-
Prevalence of non- intimate partner rape	11.4	10.7	2.0	3.2	1.3	0.5
Prevalence of attempted rape	16.0	7.7	3.6	6.2	-	-
Prevalence of sexual harassment	23.3	-	-	-	-	-
Prevalence of sexual harassment in schools	9.2	-	-	-	-	-
Prevalence of sexual harassment at work	17.5	-	-	-	-	-

Table one shows that:

- Of all women interviewed in the study 67% had experienced some form of GBV in their lifetime, while 44 % of all men said they perpetrated some form of violence.
- The most common form of GBV experienced by women is IPV with 62% women reporting lifetime experience and 47% of men disclosing perpetration.
- The most common form of IPV is emotional followed by physical, economic, and sexual violence.
- Almost equal proportions of women (11%) reported experiencing and men (10.7%) reported perpetrating rape in their lifetime.
- Of all the women interviewed, 16% experienced attempted rape while 8% of the men in the sample disclosed attempted rape of a non-partner.
- Almost a quarter of women who were ever pregnant (24%) experienced abuse during their pregnancy.
- Almost a quarter (23%) of all the women interviewed said they had experienced sexual harassment at school, work, in public transport or at the healers.

Patterns and drivers of GBV

Individual factors

Table two: Socio-demographic factors associated with experience and perpetration of IPV

Factors	Ever IPV		Past 12 months IPV	
	% women survivors	% men perpetrating	% women survivors	% men perpetrating
Age				
18-29	65.7	52.8	39.4	28.5
30-44	65.7	48.6	30.8	26.0
45+	54.3	38.5	9.2	8.1
Level of education				
High school incomplete and lower	60.7	42.3	24.4	17.5
High school complete and over	65.8	54.7	35.8	29.2
Worked in past 12 months				
No	59.4	40.5	25.6	15.6
Yes	67.6	53.7	33.6	28.1

Table two shows that:

- Women between the ages of 18-44 experienced the same level (66%) of IPV in their lifetime. There was a relatively small difference between the levels of perpetration of IPV by men in the 18-29 (53%) and 30-44 (49%) age groups.
- Women aged 45 and over experienced lower levels (54%) of IPV in their lifetime compared to younger women.
- Men aged 45 and over perpetrated lower levels (39%) of IPV in their lifetime compared to the younger men.
- Women who were educated beyond high school experienced higher levels (66%) of IPV than women with lower levels (61%) of education.
- Similarly, men with higher levels of education perpetrated higher levels (55%) of IPV than men with lower levels (42%) of education.
- In the 12 months prior the survey a third of the women in the sample who were employed as opposed to a quarter of the sample who were unemployed experienced violence.
- In the same period, 28% of men in the sample who were employed perpetrated violence as opposed to 16% of those unemployed.

Childhood experiences of violence

- Eighty eight of women and 66% of men reported being abused as children; most of this physical abuse.

Table three: Child sexual abuse as a risk factor to experience or perpetration of GBV in adulthood						
	Any sexual IPV		Any physical IPV		Any rape	
	% women survivors	% men perpetrating	% women survivors	% men perpetrating	% women survivors	% men perpetrating
Experience of child sexual abuse	19.6	18.7	45.7	39.3	22.6	24.8
No experience of child sexual abuse	12.9	4.3	31.7	24.5	7.7	7.0
	p=0.06	p=0.000	p=0.02	p=0.02	p=0.000	p=0.000

- Child sexual abuse was associated with the experience and perpetration of IPV and non-partner rape.
- High proportions of women (56%) and men (26%) witnessed their mothers being abused.
- About a quarter (24%) of men who perpetrated IPV in the 12 months prior to the survey also consumed alcohol in the same period.
- Over a fifth of the men (22.4%) who admitted to perpetrating IPV during the 12 months prior to the survey also admitted to using drugs.

These findings concur with the ecological model of IPV, which posits that individual childhood and interpersonal experiences affect attitudes and behaviour in adulthood.

Alcohol and drug use

- A significantly greater proportion of men who drank alcohol in the 12 months to the survey were more likely to perpetrate IPV than men who did not drink alcohol.
- Thirty two percent of women and 60% of men in the study drank alcohol in the 12 months to the survey.
- Nineteen percent of men who drank alcohol perpetrated IPV in the 12 months to the survey.
- Fourteen percent of men drinkers perpetrated emotional IPV in the 12 months prior the survey.
- Five percent of men drinkers perpetrated sexual IPV in the 12 months to the survey.
- Thirteen percent of women whose partners drank alcohol experienced emotional IPV in the 12 months to the survey.
- Twelve percent of women whose partners drank alcohol experienced economic IPV in the 12 months to the survey.
- A tenth of women whose partners drank alcohol experienced physical IPV in the 12 months to the survey.
- Thirty three percent of men drug users perpetrated emotional IPV in the 12 months to the survey. Twenty one percent of men drug users perpetrated economic IPV.
- Sixteen percent of men drug users perpetrated physical IPV in the 12 months to the survey. Twelve percent of men drug users perpetrated sexual IPV in the 12 months to the survey.

Relationship factors

- More than half of the women (53.3%) who experienced IPV in the last 12 months suspected that their partners were having sex with someone else.

Community factors

Table four alongside shows that:

- Almost similar proportions of women (83.1%) and men (81.9%) agree that men and women should be treated equally.
- Over three quarters (78.5%) of women and almost nine out of ten (88.9%) men agreed that a woman should obey her husband.
- Twenty one percent of women and 38% of men agree that if a man has paid lobola for his wife, she must have sex when he wants it.
- Seven percent of women and 18.3% of men agreed that if a woman is raped she is usually to blame for putting herself in that situation.
- These findings show that although gender equality in the public domain is widely accepted this is not the case in the private sphere.

Table four: Gender attitudes		
	Women strongly agree/agree %	Men strongly agree/agree %
I think people should be treated the same whether they are male or female	83.1	81.9
I think a woman should obey her husband	78.5	88.9
I think this a man should have the final say in all family matters	28.4	54.3
I think a woman needs her husband's permission to do paid work.	43.6	54.0
I think it is possible for a woman to be raped by her husband	54.3	48.8
I think that a woman cannot refuse to have sex with her husband.	36.7	48.5
I think that if a man has paid Lobola for his wife, she must have sex when he wants it	20.5	37.7
I think that if a man has paid Lobola for his wife, he owns her	22.7	44.7
I think that if a wife does something wrong her husband has the right to punish her	23.1	37.1
I think that in any rape case one would have to question whether the victim is promiscuous	18.2	30.4
I think in some rape cases women actually want it to happen	11.7	29.3
I think if a woman doesn't physically fight back, it's not rape.	12.5	21.2
I think that when a woman is raped, she is usually to blame for putting herself in that situation	7.3	18.3
I think that in any rape case one would have to question whether the victim is promiscuous	18.2	30.4

Societal factors

Political environment

Table five: Political leadership	
Criteria	%
Percentage of GBV speeches by politicians which mention GBV	15
Percentage of GBV speeches by politicians which refer to GBV as main topic	6
Percentage of GBV speeches by politicians which refer to emotional abuse	1.1
Percentage of GBV speeches by politicians which refer to physical abuse	2.3
Percentage of GBV speeches by politicians which refer to sexual abuse	11.9
Percentage of GBV speeches by politicians which refer to economic abuse	1.1
Percentage of GBV speeches by politicians which refer to domestic violence	7.4
Percentage of GBV speeches by politicians which refer to femicide	8
Percentage of GBV speeches by politicians which refer to the link between GBV and HIV	10.4

Table five shows that:

- Of the 188 speeches analysed, 15% referred to GBV but only six percent had GBV as the main topic.
- Most of the GBV speeches (11.9%) referred to sexual abuse.
- Eight percent of speeches addressed the issue of femicide or passion killings.
- A tenth of the GBV speeches referred to the link between GBV and HIV.

Media

The results of the Gender and Media Progress Study (GMPS) to examine amongst others the proportion of GBV coverage, GBV topics, who speaks, and who reports on GBV in Botswana show that:

- Only 5% of all news articles monitored in Botswana covered GBV.
- Women constitute 26% of sources on GBV in Botswana.
- Domestic violence, and legislative and political issues received the most coverage in Botswana.
- Topics that received little coverage include rape, child abuse and non-physical violence.
- The alleged perpetrators are more than three times more likely to be heard in the media than the victims and survivors of GBV.
- The media in Botswana often reports GBV in sensational ways that trivialise the experiences of women for example the reference to femicide as "passion killings".

Effects of GBV

Table six: Effects of GBV

Criteria	% Women
Physical injury	
Percentage of physically abused women who sustained injuries	18.1
Percentage of physically injured women who spend days in bed because of injuries	53.8
Percentage of physically injured women who missed work as a result of injuries	33.3
Sexual and reproductive health	
Percentage of women who were sexually abused by intimate partners and diagnosed with STI	34.1
Percentage of women who were physically abused by intimate partners and diagnosed with STI	34.2
Percentage of women who were raped by non-partners and diagnosed of STI	43.5
Percentage of women who were sexually abused by intimate partners and tested HIV positive	20.3
Percentage of women who were physically abused by intimate partners and tested HIV positive	26.1
Percentage of women who were raped by non-partners and tested HIV positive	15
Poor mental health	
Percentage of women who were abused by intimate partners and attempted suicide	9
Percentage of women who were raped by non-partners and attempted suicide	15

Table six shows that:

- Almost one in every five women (18%) physically abused sustained injuries. Over half of the injured women had to stay in bed for an average number of nine days.
- A quarter of all the women interviewed had been diagnosed with a sexually transmitted infection (STI) in their lifetime.
- A greater proportion of women who experienced IPV or rape were diagnosed with STIs compared to the proportion of women who had not experienced IPV or rape.
- A tenth of women and above a fifth of men interviewed in this study had never tested for HIV.
- About a quarter (26.1%) of the women who experienced physical IPV in their lifetime were HIV positive.
- A fifth (20.3%) of the women who experienced sexual IPV in their lifetime were HIV positive.
- Fifteen percent of the women who were raped in their lifetime were HIV positive.
- Of the women who experienced IPV in their lifetime, 8.7% attempted suicide.
- Of the women who were raped in their lifetime, 15% attempted suicide.
- Of the women who experienced IPV in the last 12 months, 11.6% attempted suicide.
- Of the women who were raped in the last 12 months, 30.8% attempted suicide.

Response and support

Table seven: Response and support indicators		
Criteria	**% Women**	**% Men**
Awareness of legislation		
Proportion of participants aware of the Domestic Violence Act	46.2	42.5
Proportion of participants aware of the Penal code sections 14 and 143	19.6	24.4
Proportion of participants aware of protection orders	33.9	31.4
Proportion of participants who know about the Ministry of Labour and Home Affairs Toll free line	25.3	31
Botswana Police Services		
Number of reported cases		
Number of rape cases recorded by Botswana Police Services Public Relations Unit in 2010	1865	
Number of rape cases reported to Botswana Police Services Public Relations Unit in January to June 2011	893	
Number of female murders by intimate partners reported to Botswana Police Services Public Relations Unit in January to June 2011	45	
Number of GBV registered cases with female victims above the age of 18 reported to BPS GBV focal points in 2011	8165	
Number of IPV registered cases with female victims above the age of 18 reported to BPS GBV focal points in 2011	4499	
Number of physical GBV registered cases with female victims above the age of 18 reported to BPS GBV focal points in 2011	5167	
Number of sexual GBV registered cases with female victims above the age of 18 reported to BPS GBV focal points in 2011	914	
Number of emotional GBV registered cases with female victims above the age of 18 reported to BPS GBV focal points in 2011	898	
Number of economic GBV registered cases with female victims above the age of 18 reported to BPS GBV focal points in 2011	178	
Number of femicide cases with female victims above the age of 18 reported to BPS GBV focal points in 2011	57	
Number of rape cases with female victims above the age of 18 reported to BPS GBV focal points in 2011	836	
Proportion of GBV cases reported to BPS GBV focal points with victims above 18 perpetrated by intimate partners	60.9	
Proportion of GBV cases reported to BPS GBV focal points with victims above 18 perpetrated by intimate partners	39.1	
Population prevalence		
Prevalence of GBV based on police statistics	1.2	
Prevalence of form of IPV based on police statistics	0.66	
Prevalence of form of physical IPV based on police statistics	0.44	
Prevalence of form of psychological IPV based on police statistics	0.17	
Prevalence of form of economic IPV based on police statistics	0.03	
Prevalence of form of sexual IPV based on police statistics	0.02	
Prevalence of form of non partner sexual violence based on police statistics	0.12	
Case withdrawal		
Number of GBV cases withdrawn in 2011	777	
Number of physical GBV cases withdrawn from BPS in 2011	554	
Number of emotional GBV cases withdrawn from BPS in 2011	70	
Number of cases sexual GBV withdrawn from BPS in 2011	65	
Number of cases economic GBV withdrawn from BPS in 2011	64	

Criteria	
Courts	
Number of GBV cases before courts in 2011	5584
Number of physical GBV cases before courts in 2011	2785
Number of emotional GBV cases before courts in 2011	592
Number of cases sexual GBV before courts in 2011	1537
Number of cases verbal GBV before courts in 2011	399
Number of cases economic GBV before courts in 2011	271
Percentage of GBV cases prosecuted by courts in 2011	36.3
Percentage of GBV cases convicted by courts in 2011	31
Percentage of GBV cases acquitted by courts in 2011	5.5
Number of GBV cases recorded at Broadhurst customary court in 2011	316
Shelters and counselling services	
Number of survivors counselled at Kagisano Women's Shelter in Gaborone in 2010	396
Number of survivors counselled at Molepolole DIC in 2011	147
Number of GBV cases recorded at Lifeline from 2009-2010	144
Percentage of speeches by politicians referring to support services	9.1

Vision 2016 is Botswana's strategy to propel its socio-economic and political development into a competitive, winning and prosperous nation. Botswana laws that relate to GBV include the Domestic Violence Act, the Penal Code, the Criminal Procedure and Evidence Act, the Employment Act and the Deeds Registry Act.

Table seven shows:

Awareness of laws

- Of those interviewed, 46.2% of women and 42.5% of men said they had heard about the Domestic Violence Act.
- Relatively low proportions of those interviewed in the sample, 19.6% of women and 24.4% of men, heard about the Penal code sections 141-143.
- Approximately a third of women and men in sample, 33.9% of women and 31.4% of men, were aware of protection orders.

Botswana Police Services

- BPS Public Relations Unit recorded 45 cases of female murder by an intimate (ex-) partner from January to June 2011.
- BPS GBV focal points recorded 8165 GBV registered cases with female victims above the age of 18 in 2011.
- The most commonly reported form of GBV was physical followed by verbal, thirdly sexual, then emotional and lastly economic.
- BPS GBV focal points recorded 4499 IPV registered cases with female victims above the age of 18 in 2011.
- The most commonly reported form of IPV to BPS was physical, followed by emotional, verbal, economic and lastly sexual.
- Only 7 % of all women ever partnered in the survey were physically abused and who reported abuse or threats to police in lifetime.
- One in nine women raped in the survey reported it to the police.
- BPS is currently collecting data for the different GBV forms in more comprehensive ways than the South African Police (SAPS). This is an example of international good practice.
- The prevalence of GBV reported in the survey is 24 times higher than that reported to the police.
- The prevalence of IPV in the survey is 44 times that reported to police in 2011.
- The prevalence of non-partner sexual violence in the survey is 17 times more than that reported to police.
- GBV victims withdrew 777 case from BPS in 2011.

Courts

- The courts dealt with 5584 GBV cases in 2011.
- The courts prosecuted thirty six percent of GBV cases received in 2011.
- Thirty one percent of GBV cases before the courts resulted in convictions.
- The courts acquitted six percent of GBV cases.
- Broadhurst customary courts dealt with 316 GBV cases in 2011.

Shelters and counselling services

- In 2010, 396 clients accessed counselling services at the Kagisano Women's Shelter in Gaborone.
- In 2011, 147 survivors accessed counselling services at the Molepolole DIC.
- Lifeline Botswana attended to 144 GBV cases in 2009-2010
- Only 9.1% of speeches made by key political speakers referred to social welfare services as the proposed support system for survivors of GBV.

Health sector

- Only 4.7% of women who experienced physical abuse and sustained injuries through an intimate partner sought medical attention in a lifetime.
- Only 1.6% of all women participating in the survey were raped and sought medical attention in a lifetime.
- One in seven women who were physically abused in the survey sought medical help for the injuries in a lifetime.
- The Botswana government through the Ministry of Health has put in place a National Sexual and Reproductive Health Programme (NSRHP) and Policy guidelines and Service Standards for Sexual and Reproductive Health which provide guidelines for the management of GBV survivors.

WAD

- The Women's Affairs Department has initiated a process of establishing a Gender Based Violence Referral System among key service providers for GBV victims and survivors.

Prevention

Table eight: Prevention indicators

Criteria	% Women	% Men
Proportion of participants who heard of the Sixteen Days campaign in the 12 months prior to the survey	16.1	18.3
Proportion of participants who heard of the 365 Days campaign in the 12 months prior to the survey	8	9
Proportion of participants who access information on GBV from radio	54.2	55.7
Proportion of participants who access information on GBV from TV	23.2	10.7
Proportion of participants who access information on GBV from newspapers	10.9	20.2
Proportion of political speeches referring to prevention	12	

Table eight shows that:

- Less than half of the sample, 47.9% of women and 48.6% of men, knew of events or prevention campaigns to end GBV.
- Less than a fifth of the sample (16.1% of women, and 18.3% men) had heard about the Sixteen Days of No Violence Against Women campaign.
- Very few people in the sample (8% of women and 10% men) had heard about the 365 Days Campaign to End Gender Violence.
- Of the sample, 7.2% women and 8.6% men participated in a march or event to protest against GBV.
- Women (62.8%) and men (51.3%) who were aware of GBV campaigns found them empowering.
- Of the 188 the public speeches analysed, only 12% mentioned methods to prevent GBV.

Other findings include:

- WAD co-ordinates the commemorations the annual national commemoration of the Sixteen Days with a civil society stakeholders.
- Civil society stakeholder involvement in the Sixteen Days activities has increased over the years.

- GL has worked with 10 local councils to develop localised action plans for preventing gender violence.
- Women Against Rape, Stepping Stones International. Faith Based Organisations, and local councils con-ducted GBV prevention initiatives and events in 2011.
- Print media should improve on coverage of GBV.

Integrated approaches

- Botswana has a draft National Action Plan to End Gender Violence developed in 2007.
- Government has not formally adopted the plan, last reviewed in 2010.
- Government has not made budgetary allocations for the implementation of the plan.
- There are, however, notable achievements by government and civil society implementing some of the actions in the NAP, for example:
  - The commencement of a process to develop a GBV referral system.
  - Development of the Ministry of Health's Framework for the Health Sector's Response to GBV.
  - Development of the Sexual Abuse Strategy by the Department of Social Services.
  - Establishment of Gender Committees at district level which mobilise communities and raise awareness of GBV.
  - Community policing programmes.
  - GBV sensitisation and awareness raising.
  - Increased stakeholder participation in the Sixteen Days campaign.
- Botswana has made significant progress in addressing HIV and AIDS. The prevalence of HIV in Botswana is levelling out at approximately 17%[1]. In 2009, Botswana had an estimated 350 557 living with HIV compared to an estimated 5.6 million [5.4 million-5.8 million] HIV-positive people in South Africa that continues to have the world's largest HIV epidemic.[2] The integrated strategy to address HIV and AIDS in Botswana provides important lessons to address the high levels of GBV.

Conclusions and recommendations

The table summarises the main conclusions and recommendations of the study:

Table nine: Conclusions and recommendations

Conclusions	Recommendations	Who responsible
Extent		
Botswana has high levels of GBV. Emotional partner violence, a form not usually addressed is most common.	Publicise and disseminate findings of this report widely.	WAD, GL and all stakeholders involved in the study
	Use the findings to lobby government and political leaders to place GBV as a key priority on the political agenda and allocate resources for periodic GBV surveys using the same methods.	
	Use the indicators research to strengthen local level efforts to end violence through establishing baselines; monitoring and evaluating progress towards reducing GBV in the Centres of Excellence for Mainstreaming Gender in Local Government.	WAD, GL, BALA, Ministry of Local Government and Local councils
The survey gives more account of the extent of GBV than police or other administrative data.	Conduct further research to ascertain why women do not report GBV to the police or to health services.	Researchers, Academia
Drivers and patterns		
A complex set of factors drive the perpetration of GBV in Botswana. Alcohol use, drug use, child abuse, multiple sexual relationships, conservative community beliefs and values, and patriarchal gender attitudes are major drivers of the GBV pandemic in Botswana.	Step up campaigns to wipe out substance abuse.	Department of Social Services
	Develop workplace and school based GBV prevention initiatives.	Ministry of Education, all Government departments and private sector

[1] Progress report of the national response the 2001 Declaration of Commitment on HIV and AIDS, Botswana country report 2010, Reporting period: 2008-2009.
[2] http://www.unaids.org/documents/20101123_FS_SSA_em_en.pdf

Conclusions	Recommendations	Who responsible
GBV experiences are cyclical occurring more than once.	Develop GBV programmes with targets messages to youth.	WAD and GBV stakeholders
	Prioritise child rehabilitation programmes.	Department of Social Services
	Place behavioural change and changing gender attitudes at the centre of all prevention campaigns.	WAD and GBV stakeholders
	Further research is required into impact of each of the identified factors and how they interact in models for risk factor analysis.	Researchers, Academia
Effects		
Women who experience GBV in Botswana are at increased risk of STIs, HIV and psychological effects.	Prioritise the provision of sexual assault, mental health and counselling services as a means of responding to GBV.	Ministry of Health, Civil society
Response and support		
Botswana police Services have made significant progress in terms of GBV data collection and management but data archived at national headquarters lacks detail.	Move from paper registers to an automated data entry and management system that is accessible to focal points from all police stations.	Botswana Police Services
	Publicise the annual GBV statistics widely for the purposes of informing the public and decision makers on extent of violence reported.	
Shortage of GBV focal points to be on call on an around the clock basis in police stations.	Train more police officers on handling GBV cases.	WAD
Challenges identified by GBV focal points include shortage of vehicles and office space were victims can be attended to in private.	Allocate more financial resources for vehicles and office space for GBV focal points.	Ministry of Finance
GBV service providers for example the Health sector, district commissioners, social services, magistrates' courts, and other NGO GBV service providers need to improve on the documentation of GBV cases dealt with.	Develop and institutionalise a referral system. Develop a decentralised and automated surveillance system for monitoring the effectiveness of the referral system.	WAD
There are only two shelters for abused women in Botswana. These are inadequate for the high levels of GBV reported in this study.	Government should provide for facilities of protection as specified in the Domestic Violence Act.	Ministry of Finance
Prevention		
Prevention campaigns and protective laws are still relatively unknown to the public.	Prevention needs to be placed at the centre of campaigns to end GBV in the same way that HIV and AIDS.	Office of the president, all national government ministries; chiefs and traditional authorities; Local government and civil society
The findings in this research point to conservative and patriarchal value systems for women and men as a contributing factor to the incidence of GBV.	Awareness raising and community dialogues on GBV and other gender issues should be prioritised.	GL, BALA, Ministry of Local Government, NGOs and CBOs working at the local level

Conclusions	Recommendations	Who responsible
Political leaders are not addressing GBV as a key social problem. This is shown by the limited reference to GBV in speeches.	Declare a national emergency be declared based on this study's findings followed by a call for more efforts to address GBV.	Presidency, Cabinet, Parliamentarians, Mayors, Chiefs, Councillors, Political party representatives
Integrated Approaches		
Botswana has not yet formally adopted the draft NAP.	Use the indicators research to review and strengthen the NAP by adding baseline information, targets and indicators.	WAD and all GBV stakeholders
	Ensure the adoption, costing and implementation of the NAP. Fund and conduct follow up and periodic GBV surveys using the	WAD and all GBV stakeholders
	same methods. Follow up surveys will be useful in gauging the reduction of GBV and the effectiveness of efforts to address GBV	Ministry of Finance, WAD
	Develop and maintain a national GBV database.	Statistics Botswana

CHAPTER 1
Introduction



Young people marching against gender violence in Nata. *Photo by Vincent Galatlhwe*

Key facts

- ✓ The SADC Protocol on Gender and Development sets a target for SADC member states to halve GBV by 2015.
- ✓ Although previous research indicates that GBV is a flagrant violation of human rights in Botswana, there is lack of recent comprehensive data on its extent, causes and effects.
- ✓ Various studies investigated the underlying causes of GBV in Botswana; identifying amongst others gender attitudes, alcohol abuse and conflict as a result of infidelity.
- ✓ There is a need to establish baseline indicators for measuring GBV much of which is under-reported or unreported.
- ✓ GL and WAD implemented this study to fill this critical information gap.



"At the age of 17 I (Elinah[3]) dated a 26 year old man. We loved each other so much that we could not stand to stay away from each other. Four years later, I fell pregnant. Since I was not married my parents called him to ask him if he was responsible for the pregnancy and what he was planning to do about it. He accepted and told them of his plans to marry me.

During the pregnancy, I moved to his house in town so that he could support me and my baby. I had the baby while staying with him. After I had the baby all the happiness we once shared disappeared.

He began to change and never spent time with me. He started cheating on me and coming home late, around 2 am. He would wake me up upon arrival and ask for food. I would do whatever he told me to do. When the food was served he would complain that it was not well cooked and throw it away.

He brought girls home. He said they were his friends. He would offer them the guestroom and sneak out at night leaving me and the baby to sleep alone. One day he beat me up because I complained about his behaviour.

It was too much for me. I moved to my sister's house since my baby was still very small. He followed me to my sister's place and harassed me saying that I ran away because the baby was not his. He stopped supporting the baby as he had promised. When I confronted him he would beat me up in front of my sister. I went to the village to live with my parents.

I reported him to the court for not supporting the baby and for physically abusing me. After the court hearing he promised to support us. That was the last time I saw him."

Elinah's story illustrates the multiple forms of gender violence that women face in their lifetime. Elinah's partner cheated on her, brought girlfriends home, beat her up and denied being the father of his child. After experiencing this Elinah sought help from her family and the courts.

Her story highlights the experiences of most women who leave abusive relationships. They lose their homes, financial support, and struggle to hold onto their dignity. Elinah is one of the 67.3% of women in Botswana whose right to safety and security as guaranteed in the Botswana Constitution, is compromised. This chapter provides the background and rationale to the GBV indicators research; unique features; country context and previous research.

Background and rationale

GBV is one of the most common yet unacknowledged and serious human rights violations in the Southern African Development Community (SADC) region[4]. In response to the high levels of violence, and the 2006 call by the UN Secretary General to all member states

[3] Not her real name
[4] Gender Links SADC Gender Protocol Alliance Barometer, 2010.

to develop plans for ending Gender Based Violence (GBV), many Southern African countries have shifted from campaign mode to a more integrated programmatic approach to address GBV.

GL has been working in the gender justice arena for the last eleven years, using the Sixteen Days of Activism on Violence Against Women as a platform for training activists in the SADC region in strategic communications. These campaigns led to inevitable questions about how activists sustain such campaigns beyond the Sixteen Days. In 2006, GL began working with nine countries in the SADC region to extend the Sixteen Days to a 365 Day National Action Plan strategy to end gender violence.



Developing action plans inevitably led to the need for reliable baseline data, targets and indicators for measuring progress in an arena where most violence is under-reported or not reported at all, leaving administrative data as an unreliable source of information.

In August 2008, SADC Heads of State adopted the Protocol on Gender and Development that, among others, aims to halve gender violence by 2015. Although Botswana is not yet a signatory to the Protocol, the government subscribes to almost all the provisions, especially those that relate to GBV. This reinforced the need for reliable baseline data against which to benchmark progress. From the outset, GL viewed this as a regional project, piloting it in Gauteng (the most populous province of South Africa) but also in the two countries where the organisation has satellite offices: Mauritius and Botswana.

Drawing on the 2007 UN Expert Group Report on developing indicators for measuring GBV, some preliminary work began in earnest in Southern Africa through an initiative supported by UN Trust Fund and spearheaded by GL. The key players included representatives of government (i.e. gender, justice, health, police, and prosecuting authority), research institutes and NGOs working on gender justice issues.

The UN Economic Commission for Africa Gender Centre (UNECA/AGC) commissioned desktop research on GBV data collection for Africa. This research found gaps in the data collected by many countries. Some countries do not even have recording systems on any aspect of GBV. Laws in the different countries do not regard certain acts of GBV as punitive violations, thus making it difficult for countries to pronounce the same messages on GBV. This is taking place despite the fact that most countries are in unanimous agreement that GBV is a gross violation of human dignity based on gender, and have committed to ending violence through international instruments like the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) and regional instruments like the SADC Gender Protocol.

In July 2008, GL convened a reference group meeting comprising 16 representatives from government, research organisations and regional NGOs focusing on gender violence. This meeting sought to get conceptual clarity on what is required as well as get buy in from key stakeholders on developing a composite set of indicators to measure gender violence that is methodologically solid; pre-tested and can eventually be applied across the region. The meeting resulted in key conceptual decisions being taken that have since informed the design of this research.

Key conceptual decisions

A stand-alone survey, not one linked to existing surveys: While there are cost and logistic arguments for a GBV prevalence survey being attached to another broad population survey (such as Demographic Health Survey; HIV and AIDS) this dilutes the focus and poses potential ethical dilemmas. GBV is a complex, specialised area requiring dedicated attention. By conducting a stand alone GBV prevalence survey (the first of its kind) GL and the South African Medical Research Council hoped to establish the principle that such studies and analysis must be routinely conducted.

GBV versus violence against women: Unlike previous studies that recruited either men or women, this study made use of two separate questionnaires: for women (focusing on their experiences of GBV) and men (focusing on perpetration) of violence against women. The focus on women is justified by overwhelming evidence (the routinely collected police data) that shows that the majority of gender violence cases consist of violence against women. Comparing women's reports of experience and men's reports of perpetration makes this study different from any other GBV study conducted in Botswana.

Combining a prevalence and attitude study: As such studies require similar sampling techniques, this is more cost effective, and allows for correlations to be drawn between experiences, attitudes and behaviour when the data is drawn from the same sources.

Using prevalence studies to determine the extent of under-reporting and rarely reported types of violence such as emotional and economic abuse: This gap is critical in understanding the effectiveness of response mechanisms, and informing policies and actions needed to improve them.

Interrogation of existing administrative data: While administrative data - that is information collected from the courts and police - is not adequate, it is important. There are several ways in which this data collection can be improved to provide more meaningful information. For example, many police services in the region do not have specific categories for gathering GBV data and this aspect is therefore not analysed in annual crime reports. The study has sought from the outset to work with the police and justice systems with the aim of improving collection, analysis and presentation of administrative data.

Photo: Roos van Dorp



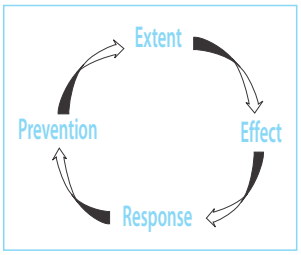
GL CEO Colleen Lowe Morna and Botswana Attorney General Dr Athalia Molokomme at the inception meeting in September 2009.

Overall the team emphasised the need to test a draft set of indicators in a pilot project at local level before these are cascaded nationally and regionally. This study would gradually build support and buy- in for a comprehensive set of indicators that provides meaningful and nuanced measures of progress or regression.

GL first held a reference group meeting in Botswana in September 2009. Participants included the Attorney General, WAD, BPS, Ministry of Health, Central Statistical Office, University of Botswana Sociology Department, WLSA, civil society organisations and other stakeholders.

Unique features of the pilot project

Unlike previous prevalence surveys that have focused on a few aspects of GBV, the set of indicators seeks to measure:



- The extent of the problem (what uniform administrative and survey data could be obtained across all SADC countries).
- The social and economic effects of GBV.
- Response and support interventions as measured by the multi stakeholder National Action Plans to End Gender Violence based on the SADC Protocol on Gender and Development.
- Prevention interventions that underscore the importance of a paradigm shift towards prevention rather than focus primarily on response.

Thus far, GL and partners have conducted the GBV Indicators Research in Botswana, Mauritius and in the Gauteng, KwaZulu Natal and Western Cape provinces of South Africa. GL launched the first *GBV Indicators Research Study* in the Gauteng Province of South Africa in August 2011. The research will be rolled out to the Limpopo province of South Africa in April 2012. GL is currently discussing the possible roll out of the study with the governments of Seychelles and Zambia.

County context

Botswana is located in Southern Africa, just north of South Africa, with Angola to the northwest, Zambia to the northeast, Zimbabwe to the east, and Namibia to the west, with a total area of 231 800 square miles (600 370 km^2).

Preliminary results of the census conducted in 2011 show that Botswana now has a population of two million people. At the time of writing this report, Statistics Botswana has not yet released the sex disaggregated population statistics from the census undertaken in 2011. According to the 2006 Demographic Health Survey, females outnumber males in Botswana with a sex ratio of 92 males for every 100 females[5].

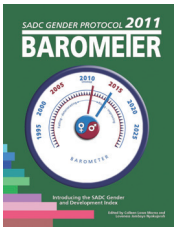


Statue of the 3 founding chiefs of Republic of Botswana in front of construction works of the new central business district .
Photo: GL Botswana

[5] Progress report of the national response to the 2001 Declaration of Commitment on HIV and AIDS, Botswana country report 2010, period 2008-2010.

Status of women

The SADC Gender Protocol Barometer 2011 rates Botswana at 70%, and ranks the country fifth after Seychelles, South Africa, Lesotho and Mauritius using the SADC Gender and Development Index (SGDI). The SGDI on the status of women consists of 23 performance indicators. The indicators are grouped into six categories, namely sexual and reproductive health (SRH) (3 indicators); HIV and AIDS (3 indicators); Economy (5 indicators); Education (3 indicators), Governance (3 indicators) and media (6 indicators). The SGDI ranks Botswana first in education and economic participation; third in HIV and AIDS; fourth in sexual and reproductive health; fifth in the media and eleventh in governance.



The Barometer also has a Citizen Score Card that measures citizen perceptions of government performance against the 28 targets of the Protocol. This differs from the SGDI in that it covers four areas where it is difficult to obtain empirical data - constitutional and legal affairs; gender violence; peace and security as well as implementation mechanisms. In areas where there are empirical measures, it also provides the nuance of perceptions. For example, a country might have a high enrolment of girls in schools, but citizens may still see in that gender bias in courses and curricula, high levels of GBV in schools etc, that provide a different perspective on such statistics. Indeed, in 2011 citizens participating in this exercise gave Botswana an overall score of 54%, placing the country 11 out of 15 in the SADC region. Whichever way the indexes are viewed, Botswana clearly has important gender gaps to be addressed.

Education

The National Development Plan (NDP) 10 states that an "educated an informed nation is seen as an important foundation and a basis for the enhancement of national productivity". The goal of education is to provide an adequate supply of qualified, productive and competitive human resources. Further, the policy goals of the education sector are to improve access, equity, relevance and quality in the education system. The government spend 30% of its annual budget in 2010/2011 on education and training during NDP 9 (NDP 10). This is a significant proportion of the national budget, which has translated into positive achievements in the education sector for girls and boys, as gender parity is evident at primary and secondary schools.

Access and equity at all levels of the education system has improved. Gender parity has been achieved in primary and secondary education (MDG 2010). In Botswana school enrolment levels are high and the enrolment of girls exceeds that of boys at all levels, except science and technology and vocational training.

Education indicators include:

- Equal proportions of women and men (83%) are literate in Botswana.
- Equal proportion of girls and boys (50%) are enrolled in primary schools.
- Fifty two percent of students in secondary schools are girls.
- Fifty three percent of students in tertiary education are girls.
- Thirty seven percent of teachers are women.
- No studies have been undertaken in Botswana to investigate GBV in schools.

Economy



Beans sold at women expo in Gaborone, Botswana. *Photo: Roos van Dorp*

Botswana is classified as an upper middle income and medium human development country by international organisations, such as the World Bank and the International Monetary Fund (UN 2010). The economy is dominated by the production and export of diamonds leading to high rates of economic growth and per capita incomes (UN/CCA 2007, NDP 10).

The Botswana economy has experienced rapid growth since independence at an average of 8.7% per year. Due to a good fiscal position and balance of payments, the government has managed to invest the revenue from the mining industry into social development areas, such as education and health, impacting positively on the education, health, social services, including water and sanitation, contributing to an improvement in the status of women and men. However, the global economic recession has drastically reduced revenue from the mineral sector, especially, diamonds, impacting negatively on economic growth and investment in key social development areas, such as, the education and health.

Botswana has made relative progress towards achieving gender equality. The number of women in administrative decision- making has improved remarkably in public and private sector. Fifty five percent of decision makers in the public sector and about 40% of decision makers in the private sector are women.

Other indicators for the economy include that:

- Fifteen percent of women and twenty percent of men are unemployed.
- Eighty two percent of women and 76% of men participate in the labour force.
- Women make up 50% of employees in central government.
- Women make up 64% of employees at local government.
- Women make up 42% of employees at private and parastatal.

Governance

Botswana has experienced multi-party democracy and good governance since independence. The country is ranked as one of the most stable democracies in the SADC region and in Africa, with a number of positive indicators of development in terms of people's ability to access basic rights, such as health and education services.

While women form a significant proportion of the electorate, they hold very few political positions:[6] 8% of Members of Parliament and 18% of local councillors. Botswana, however, has a high level of women in management and has a number of women in prominent, senior positions, for example, the Attorney General, Dr. Athalia Molokomme and Speaker of Parliament, Dr. Margaret Nnananyana Nasha.

Media



GL newsroom training gender and media training in Botswana.
Photo: Trevor Davies

The *Gender and Media Progress Study* (GMPS) conducted by Gender Links and the Media Institute of Southern Africa in 2010 as a follow up to the 2003 *Gender and Media Baseline Study* (GMBS) found that:

- There is a significant increase in the proportion of women sources from 16% in 2003, to 20% in this report. This is slightly higher than the regional average of 19%, but lower than the GMMP average

[6] Francoeur, RT and Noonan, RJ. "Botswana." International Encyclopedia of Sexuality. Kinsey Institute, 2004. Accessed from http://www.kinseyinstitute.org/ccies/bw.php on March 27, 2009.

of 24%. At 80% of all news sources, men in Botswana still prevail in the news.
- Television has the highest proportion of women as sources at 30%, followed by print at 20%. Radio - a non-visual medium - has the lowest proportion of female sources at 15%.
- Women constitute 26% of all images in newspapers in Botswana, compared to 20% of news sources in print media.

The *Glass Ceiling, Women and Men in Southern African Media* study conducted by GL in 2009 found that:
- Men constitute 58% of employees in media houses, 16% more than the 42% women employees. The proportion of women in Botswana media houses is slightly higher than the regional average of 41% women in Southern African media houses.
- Three media houses in Botswana have exceeded parity, with more women than men. The Voice newspaper has the highest proportion of women at 55% followed by Mass Media Complex Information Services at 54% and Broadcasting Services at 41%. Dikgang Publishing Company and Yarona FM still have a long way to go at 28% and 26% women respectively.
- Women constitute 24% of those on boards of directors in media houses in Botswana, compared to 28% in the regional study.
- Women occupy 30% of top management posts in media houses in Botswana; more than the regional average of 23% women in top management.
- Women make up 39% of those in senior management in media houses in Botswana; higher than the regional average of 28%. The Botswana and regional findings for women in senior management show that women are more likely to appear in junior positions than senior management positions.

HIV and AIDS

Botswana has the second highest level of HIV and AIDS in Southern Africa after Swaziland. The prevalence indicators for HIV include that:
- 17% of the population are living with HIV[7].
- 58% of people living with HIV are women[8].
- 40% of women aged 15-24 have comprehensive knowledge on HIV and AIDS[9].

Starting in the late 1990s, based on evidence of a 38% HIV prevalence, the government of Botswana made key decisions to prioritise a comprehensive program for HIV prevention treatment and care[10]. The government increased its funding for HIV from less than $5 million in 1999 to $ 348.2 million in 2010.

The government partnered strategically with the Centre for Disease Control, Merck Foundation, Bill and Melinda Gates Foundation and the Harvard AIDS Institute. Through this partnership, Botswana became the first country in the SADC region to offer free antiretrovirals. As at 2010, 93.2% of adults and children are known to be on treatment 12 months after initiation of antiretroviral therapy[11].

HIV and AIDS continues to be a key priority in the 2010 National Development Plan (NDP 10), with emphasis on prevention strategies.

In 2010 a relatively high proportion of the increased health budget went to addressing the HIV challenges (UN 2010, NDP 10). The current National HIV Prevention Strategy recognises the mainstreaming of gender equality and youth social concerns as integral to effective prevention strategies. The Women's Affairs Department (WAD) supported by UNAIDS, civil society and the African Comprehensive HIV and AIDS Partnerships (ACHAP) are developing prevention plans of action to address the major social drivers of HIV that makes women and girls vulnerable.

Analysts attribute Botswana's success in gradually stemming the HIV and AIDS tide to strong political

[7] UNAIDS 2010
[8] UNAIDS 2010
[9] WHO 2010. Health related Millenium Development Goals.
[10] Centre for Strategic and International Studies. (2004). Botswana's strategy to combat HIV and AIDS. Lessons for Africa and President Bush's Emergency Plan for AIDS Relief. A conference report of the CSIS Task Force on HIV and AIDS. Washington DC.
[11] Progress report of the national response to the 2001 Declaration of Commitment on HIV and AIDS, Botswana country report 2010, period 2008-2010.

leadership in this area. National leadership acknowledged the HIV and AIDS epidemic and insisted on radical solutions to address the problem. Botswana adopted a comprehensive approach including prevention, treatment and care out of a realisation that the three components reinforce each other. Botswana's partnership with the private sector and donor organisations provided a model for co-ordinated and multi-sector assistance that had benefits.

Sexual and reproductive health

In the area of sexual and reproductive health key performance indicators are:

- Fifty two percent of sexually active women are using contraceptives[12].
- The maternal mortality rate is 519 women per 100000[13].
- Ninety five percent of all births are attended by skilled personnel[14].

Political and social context of GBV

GBV occurs as a result of unequal power relations between women and men. Botswana like all SADC countries has strong patriarchal roots. Men continue to dominate political decision-making within traditional political forums, such as the "kgotla," Ntloya Dikgosi (House of Chiefs) and parliament.

To eradicate the victimisation of women that is justified by cultural norms the government has enacted several laws which protect women from abuse and discrimination. The main law protecting women from violence is the Domestic Violence Act passed in 2008. The Act provides for support and protection from domestic violence. In the Botswana context "domestic violence" is any controlling or abusive behaviour that harms an individual's health or safety including physical abuse or threat; sexual abuse or threat; emotional, verbal or psychological abuse; economic abuse; intimidation; harassment and damage to property in the scope of a domestic relationship (Domestic Violence Act, 2008).



Kgatleng GBV task force in collaboration with churches marchling to end GBV in Botswana. *Photo: Keabonye Ntsabane*

[12] Botswana Ministry of Health, personal communication.
[13] www.lancet.com
[14] www.lancet.com

Some key GBV related issues that are currently on the social and political agenda in Botswana are the murder of women by intimate (ex-) partners, or so called "passion killings", where the perpetrator in most cases commits suicide after killing his partner. In the 12 months prior to the research, male intimate partners murdered 45 women.

Previous GBV research



Protesting against GBV at the Sixteen Days of Activism in Nata, Botswana.
Photo: Vincent Galatlhwe

Extent of GBV

GBV is common in many Batswana households[15]. GBV occurs predominantly within the household set up, hence is often used interchangeably with the term "domestic violence". Women across all distinctions by class, colour, tribe, education, religion, and age fall victim to abuse in their various relationships.

Results from two studies conducted in 1999 by the Botswana Police Service (BPS) and WAD indicated that violence against women had increased over time. The BPS conducted a study between 1996 and 1998 on the number of reported cases of rape and defilement of girls below the age of 16 at 25 police stations throughout Botswana. The key findings of the study were:

- Reports of rape rose by 18% over the three-year period.
- The reported cases of defilement rose by an alarming 65%.
- About 58% of all victims of rape or defilement were between 16 and 30 years old, 27% of those were under 16.
- The majority of the suspects were males between the ages of 18 and 32.
- Men known to their victims committed more than two thirds of all rapes.
- The increase may be attributed to increased awareness and reporting or the increased availability of police statistics as a result of advocacy[16].

The WAD Study on the *Socio-Economic Implications of Violence against Women*, commissioned in 1999, sought to establish the forms; extent and economic implications of GBV. The results showed that:

- Three out of every five women (60%, compared to 67% in this study) survived one or more forms of violence.
- GBV can be sub-divided into ten categories: physical slaps, severe beatings, sexual harassment, rape and sexual assaults, incest, verbal and emotional abuse and murder.
- Partners or acquaintances constitute the majority of perpetrators showing that violence against women is primarily a domestic phenomenon[17].

> "Women across all distinctions by class, colour, tribe, education, religion, and age fall victim to abuse in their various relationships."

[15] Source http://www.mambaonline.com/article.asp?artid=5698
[16] Botswana Police Service (1999) Report of a Study on Rape in Botswana Gaborone: Government Printer.
[17] Women Affairs Department (1999). Report on the Study on the Socio Economic Implications of Violence Against Women in Botswana. Gaborone: Government Printer.

In 2007, the UN in Botswana commissioned a situation analysis on GBV in Botswana, building on the findings of a 2004 UN study on Women, Girls, HIV and AIDS. The study found that:

- Physical violence against women and children within the family usually takes place on an on-going basis, and sometimes leads to the murder of the woman (femicide).
- Cases of femicide doubled over the period 2004-2007. In 2007 intimate partners murdered 101 women.[18]
- Analysis of GBV offences handled by the BPS showed an increase in the total number of reported cases from 2003 to 2007.
- Rape constituted over 70% of the reported GBV cases for the period 2003-2007.

Table 1.1: GBV offences as reported by BPS for period 2003-2007

Offence	2003	2004	2005	2006	2007	% rise 2004-2005	% rise 2005-2006	% rise 2006-2007
Passion killings	54	56	85	62	101	51.8	-27	62.9
Rape	1 506	1 517	1 540	1 534	1 596	1.5	-0.38	4.04
Defilement	303	320	318	324	391	-0.31	1.56	2.06
Indecent assault on females	92	107	91	115	98	-1.49	26.3	-14
Defilement of idiots and imbeciles	16	18	31	29	17	72.2	-6.41	41.3
Incest on females	4	5	6	8	8	20	33.3	0
Total reported GBV cases	**1 975**	**2 023**	**2 072**	**2 072**	**2 211**	**2.42**	**0**	**6.7**

Source: Botswana Police Service - extracted from report entitled "Handling of Gender based Violence cases by the Botswana Police Service".

Table 1.1 shows the number of reported cases to BPS from 2003 to 2007. Over the period, rape increased by 11.9%, with the highest increase between 2006 and 2007. Table 1.1 also shows that femicide or so called "passion killings" formed a significant proportion of violence against women in the defined period. Between 2003 and 2006, 91% of female murders, categorised as "passion killings" constituted the bulk of all murders recorded[19].

Causes

Various studies have investigated the underlying causes of GBV in Botswana. Causes identified include gender attitudes, alcohol abuse and conflict as a result of infidelity.

Gender attitudes

Violence against women in Botswana has its roots in culturally based perceptions which subordinate women to men as well as gender stereotyped roles that perpetuate and tolerate the use of violence against women[20]. Mookodi in the study *The dynamics of Domestic Violence against Women in Botswana* reported that acts of violence are a manifestation of these unequal power relations between men and women in relationships[21]. According to that study, men use violent behaviour to establish power and control over women through fear and intimidation. The escalation of incidence of GBV over the years was attributed to the shifting gender roles due to the process of general social and economic change in Botswana.

[18] UN Botswana (2009). "Situation Analysis on Gender Based Violence in Botswana". Gaborone, Botswana.
[19] Thuso Psychotherapy (2008). Report on Handling of Gender Based Violence cases by Botswana Police Service. Prepared for Women's Affairs Department, Chobe House, Gaborone.
[20] Botswana Council of Non-governmental of non-governmental organisations (BOCONGO) 2009 Shadow report to CEDAW: The implementation of the convention.
[21] Mookodi G (2004). "The dynamics of Domestic Violence against Women in Botswana'. Pula: Botswana Journal of African Studies, 18 (1).

Alcohol abuse

Although alcohol abuse may not be cited as the root cause of domestic violence it acts in concert with other factors, such as stress emanating from socio-economic challenges, to contributing towards acts of violence. A qualitative study conducted in 2005, revealed that in almost all the cases studied, violence in the household seemed to be alcohol related. In the same study alcohol abuse and related violence was most prevalent during weekends and month ends when male workers received their wages[22].

Multiple relationships

In 2003 after reports of femicide also called "passion killings" researchers sought to understand the underlying factors of such acts. Mookodi reported that passion killings were a result of the demands of modern life that have led women to pursue economically motivated and multiple relationships. Such relationships challenge male domination, betray male trust and to provoke male partners to murder their female partners[23].

Effects

Violence against women violates, impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms. The 1999 WAD study concluded that there were personal costs to women and their dependents as a result of GBV which included loss of productivity and absenteeism, loss of income, medical expenses, as well as expenses for socio-legal services. Institutional costs that were identified included social welfare services, prosecution and imprisonment of suspects and convicted perpetrators.[24]

Why this research

Although previous research indicates that GBV is a serious violation of human rights in Botswana, there is a lack of recent comprehensive data on its extent, causes and effects. Many types of GBV do not enter police statistics at all. Without comprehensive information, it is not possible to take effective corrective measures. WAD and GL undertook the GBV Indicators Research Project to fill this critical information gap.

[22] Phorano O et al. "Alcohol abuse, gender-based violence and HIV and AIDS in Botswana: establishing the link based on empirical evidence." Sahara J, 2005 Apr;2(1):188-202.
[23] Mookodi G (2004). "The dynamics of Domestic Violence against Women in Botswana'. Pula: Botswana Journal of African Studies, 18 (1).
[24] Women Affairs Department (1999). Report on the Study on the Socio Economic Implications of Violence Against Women in Botswana. Gaborone: Government Printer.

CHAPTER 2
Methodology

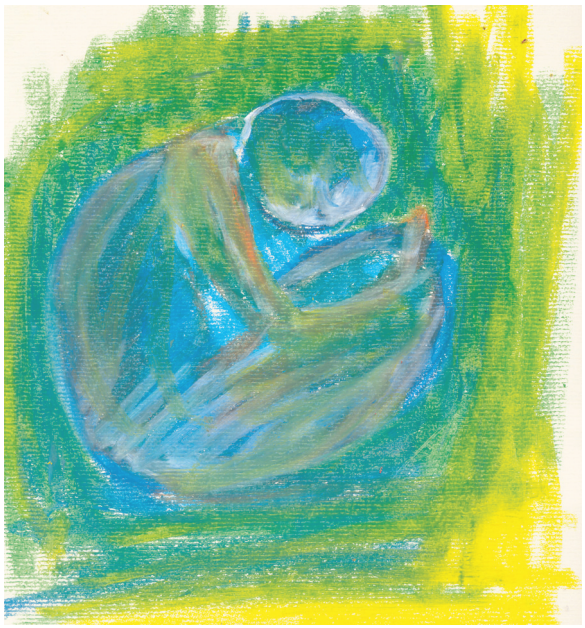


Interview in Tlokweng village during GBV Indicators fieldwork. *Photo by Oarabile Monggae*

Key facts

The GB Indicators Study employed five tools:

- ✓ Prevalence and attitudes household survey;
- ✓ An analysis of administrative data from the police, shelters, health services and social services;
- ✓ The *"I" Stories* or first hand accounts methodology;
- ✓ Political content analysis; and
- ✓ Monitoring media coverage of GBV.



"I (Milly[25]) thank God for giving me an opportunity to write my story about the pain and suffering my husband and his girlfriend caused me. At first when he mentioned "marriage" I thought "wow", what a happy life.

It all started in November 2008. I was sleeping with my three kids, when my husband arrived. I was on my way to open the door when I heard a loud bang on the door. I rushed to open the door.

He was so drunk and did not utter a word until we reached the bedroom. Just as I was climbing into bed he held me down and raped me. Afterwards he asked me to go back to my mother's compound.

It was a painful experience. When I asked him why, he started punching me and told me he had found someone else. As we were arguing his phone rang and he decided to answer on a loud speaker mode, a girl was talking on the other side and said, "When are you going to chase that dog out, how long am I going to stand here?"

Surprisingly, the woman was standing right in front of our main gate. My husband started packing my stuff and threw all the bags outside. I put my five-year-old son on my back and carried the smaller one in my hands. I led my ten-year-old boy outside. We walked in the dark and it was a painful experience, carrying the kids and luggage at the same time.

I went to my aunt's place and as I knocked she asked what the matter was, I told her and she asked me to go back to my husband as she will talk to him in the morning. I then decided to go to my parent's house. They welcomed me. The next morning I decided to go fetch my son's uniform.

As I approached the house I heard music, I knocked and waited. The door opened and a lady, wrapped in my own towel, opened the door. She threw cold water all over me. She closed the door behind her and all I could hear were my high heeled shoes as she walked towards the kitchen. I just stood there for some time and asked God, "Why me of all the people?"

I went back to my mother's place and continued asking myself questions that I had no answer's to. All this time he did not support the kids. I decided to take him to court for maintenance. The magistrate turned out to be his close friend. He told me my husband had too much debt and could not support me,I told myself I am not going to let my kids suffer because of a man.

I said to myself, "I am alive why can't I find a job?" A Good Samaritan came my way and offered me a job in her firm as a receptionist. Thumbs up to the Women Against Rape for the Economic Empowerment Programme they had offered.

In April 2009, I received a letter from his legal advisors that he has instructed them to help with a lawyer to carry out divorce proceedings against me. That very same day, I met his girlfriend in town and she started shouting at me telling me she was pregnant with my husband's child. She told me the reason why he left

[25] Not her real name.

me is because he wanted to marry her. I reported the matter to the police but no action was taken.

We stayed separately until, in April 2010, my second child got sick. My husband's girlfriend used to come and peep through the windows of Delta Medical ward where we were admitted. Unfortunately our son passed away in May. To my amazement not even a single person from my husband's family attended the funeral. My husband brought money to assist with funeral arrangements. I later discovered that the amount he claimed at work was four times the amount he brought home.

In July he came home and told me he wanted to reconcile and that the girl had given him 'muti' to own him. I asked him if he was ready for counselling. He agreed. We attended sessions for counselling together and I was surprised to learn that he has long stopped drinking and he was now going to church. I am now living a positive life with my husband and kids. He knows his role as a husband, father, and most of all he is taking good care of us and has promised not to let anything bad happen to us. This was indeed a life of hell, filled with misery but now I am the happiest woman on earth. The bad time is over but memories still come back sometimes."

This story highlights the complex nature of human relations linked to GBV. Milly's husband brought home a girlfriend, called her names including calling her a "dog". He forced her and the children to leave their home in the middle of the night. Milly experienced multiple forms of violence.

After living with his girlfriend for years and having a child with her, he returned to Milly and she accepted him. Many women leave abusive relationships but still reunite with their abusive partners for a variety of reasons ranging from economic, to societal expectations, even to love. The roller coaster ride between love and hate for their partners has substantial emotional impact on GBV survivors. Both Milly and her husband attended counselling. They now enjoy a happy life together.

While many people would not understand why Milly took her husband back it is important that she knows that there is support available to her whenever she needs it. Strategies to address GBV are not simple and require an understanding of the complex human emotions that play out in these contexts. In particular they require a much keener understanding of the importance of psycho-psycho support in response mechanisms: an area often under-resourced and neglected.

This chapter outlines the all tools used to gather the data for the GBV Indicators in Botswana. The five tools provide different prisms from which to view GBV. The use of several tools - quantitative and qualitative - reflects the complexity of the subject and the need for more than one tool to triangulate, interrogate and interpret the data in ways that strengthen policy-making and action planning.

Definition

The 1993 UN Declaration on the Elimination of Violence against Women describes the term "violence against women" as any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life. This definition encompasses, but is not limited to:

- Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs. Acts of violence against women also include

forced sterilisation and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection.

Objectives

This project sought to contribute to the halving of current levels of GBV in Botswana by 2015 through a comprehensive assessment of the extent, effects and response to GBV . This work is expected to lead to policy changes and to the adoption and strengthening of a National Action Plan to End Gender Violence (NAP) in the second quarter of 2012. It also aims to strengthen efforts at the local level to end gender violence through cascading the study to council level to provide the specific data required to inform local-level interventions.

Specifically the project aimed to:

- Quantify the prevalence of GBV in all its different forms and determine the extent of under-reporting;
- Quantify the economic, social and psychological costs of GBV;
- Assess the effectiveness of the response to GBV of the criminal justice system, health and other social services, from the point of view of the prevalence study respondents;
- Assess the way GBV is covered by the media, how this is perceived by audiences and the extent to which the media is playing its role in helping to end or perpetuate GBV;
- Assess the level of political commitment to address GBV;
- Map the underlying attitudes towards gender equality that fuel GBV;
- Assess the effectiveness of prevention campaigns from the point of view of some of the respondents to the prevalence study;
- Provide pointers for government and civil society in Botswana to strengthen strategies for preventing and responding to GBV.

Key elements of the project

This study used a combination of research methodologies to test a comprehensive set of indicators and establish a baseline of GBV in Botswana. The project components are:

- Prevalence and attitudes household survey;
- Analysis of administrative data gathered from the criminal justice system (police, courts), health services, and government-run shelter;
- Qualitative research of men's experiences of IPV as well as first-hand accounts of women's and men's experiences, or *"I" Stories*.
- Media monitoring.
- Political discourse analysis.

Prevalence and attitudes survey

The purpose of a prevalence and attitudes survey is to investigate the extent and individual effects of GBV, the underlying factors that influence GBV and to find ways to use this data to improve prevention messages and interventions.

Questionnaires measured GBV experienced by women and perpetration by men, underlying gender attitudes, selected health-related behaviour and exposure to prevention campaigns among women and men.

Researchers conducted the Botswana survey in November 2011. The researchers covered the nine districts of Botswana.



Waiting to conduct an interview after the interviewee fed his goats.
Photo by GL Botswana

Study design

The survey was cross-sectional and population based targeting at adult women and men above the age of 18 residing in preselected households.

Sampling

GL and WAD employed a two stage proportionate stratified design. They firstly selected a random sample of 100 Primary Sampling Units (PSUs) from the sampling frame provided by the Central Statistics Office. GL and WAD randomly allocated fifty PSUs to women and men each. PSUs are the main areas in which to locate the households for men and women. Researchers randomly selected 20 households in each PSU using an interval method.

The study targeted 1500 households. The researchers reached 1457 houses resulting in 97% contact rate. Of the sampled households, 99% had a woman or man over 18, making them eligible. Researchers administered a total of 1229 questionnaires: 639 to women and 590 to men.

Inclusion criteria

Eligible men and women needed to be aged 18 years or older, normally resident in the sampled household and apparently mentally competent to complete the questionnaire. When researchers found more than one potentially eligible respondent in a household, they enumerated potentially eligible respondents by writing names on a piece of paper and drawing one name from the pool.

Ethics

The Ministry of Health's Health Research and Development Division gave ethical clearance for the study in July 2010.

Researchers invited participants to participate voluntarily. They told them that non-participation would not affect them in any way. Respondents were informed that they could skip any question they chose and could withdraw from the interview at any time. Participants received an information sheet about the study, read to them when necessary. After the full briefing, respondents signed a consent form for the interview.

To ensure anonymity, researchers identified all questionnaires using non-consecutive study ID numbers. The study thus cannot link identified individuals to their questionnaires.

Questionnaire development

GL and WAD translated the initial questionnaire from English into Setswana and from Setswana back into English. Multilingual speakers verified the consistency of the questionnaires before WAD and GL finalised these.

Questionnaire content

The study employed two questionnaires: one for women as survivors and the other for men as perpetrators. The women's questionnaire aimed to describe the prevalence and patterns of women's experience of GBV, HIV risk behaviour, pregnancy history, mental health, help-seeking behaviour after experiences of GBV, gender attitudes, and exposure to media and prevention campaigns. The men's questionnaire aimed to describe men's perpetration of GBV, gender attitudes, HIV risk behaviour, fathering, and exposure to prevention campaigns.

The questionnaire provides information about the following areas:

- A description of gender attitudes, attitudes towards rape and relationship control among women and men;
- A description of the prevalence and patterns of childhood trauma among women and men;
- A description of the experiences of witnessing and intervening with domestic violence among women and men in all countries;
- A description of the risk/protective factors for experiencing GBV among women including socio-demographic characteristics, attitudes, partner characteristics, substance use;
- A description of the prevalence and patterns of women's experience of GBV, and associated health risks, including HIV risk factors including condom use, concurrent partners, number of sexual partners and transactional sex;
- A description of the health consequences associated with experience of GBV including: self-reported Sexually Transmitted Infections (STI)s, HIV testing,

unwanted/unplanned pregnancy, substance use, depression and post-traumatic stress disorder among women;

- A description of the prevalence and patterns of men's perpetration of GBV in all countries, and associated risk factors and health risks;
- Association between gender attitudes, relationship control and perpetration of GBV among men;
- Association between men's perpetration of GBV and HIV risk factors including condom use, concurrent partners, number of sexual partners, substance use and transactional sex;
- A description of the health consequences associated with perpetrating GBV in all countries including STIs, HIV testing, fathering a unplanned pregnancy;
- A description of the awareness of campaigns against GBV and relevant legislation including Domestic Violence Act and Penal Order offences against morality;
- An exploration of men's experience of IPV; and
- An exploration of economic abuse and its relationship to violence against women.



Quintin Spies from Jembi Health Systems training fieldworkers in October 2011. *Photo by Roos van Dorp*

Fieldworker training

GL trained fieldworkers prior to the survey. The field worker training covered the purpose of the study, the sampling approach, the content of the questionnaires, and a comprehensive training on the use of PDAs. The trainers carefully explained the ethics and consent processes to the researchers. Trainers observed fieldworkers during the pre-test pilot and gave detailed feedback on their approach and skills.

Community mobilisation

Access to the study sites was organised through a process of community mobilisation. Researchers first contacted the District Commissioner and the WAD district office before proceeding with fieldwork. In farming areas permission to access properties was sought from land owners to interview farm workers and other residents.

Data collection

The participants self-administered the questionnaire and chose the language of preference. A skip button allowed respondents to skip over any question they did not wish to answer. Researchers assisted participants to complete the questionnaire. The sampling frame consisted of 100 PSUs. GL allocated 50 PSUs to women and the other 50 to men to ensure the safety of survivors. In any PSU, researchers either interviewed women or men and not both. Researchers conducted the interviews in private with no other person present. The researchers also assured the respondents of confidentiality.

Data management and analysis

The researchers downloaded data daily from the PDAs and merged it into a complete dataset. WAD and GL conducted data analysis using Stata version 10 taking into account the survey's two stage sample design. To meet objectives descriptive statistics are presented in this report for the relevant variables and constructs. Data analysts compared the proportions or means for the different variables using tests of statistical significance. This report presents the results of bivariate analyses for the chi-squared tests of association between exposures and outcomes.

Characteristics of women and men participating in the prevalence and attitude study

Table 2.1: Demographic, socio-economic and relationship characteristics of participants				
	Women		Men	
	%	N	%	N
Age group				
18-29	42.7	272	43.9	258
30-44	32.5	207	32.1	189
45+	24.8	158	24.0	141
Level of education				
High school incomplete and lower	59.9	380	57.3	336
High school complete	40.1	254	42.7	250
Nationality				
Motswana	94.8	602	96.6	566
Southern African	3.8	24	3.2	19
African outside SADC	0.6	4	0	0
Other	0.8	5	0.2	1
Have you worked to earn money in the last 12 months				
No	58.7	373	47.3	277
Yes	41.3	262	52.7	309
How much did you earn before tax and including benefits				
1-500 Pula	22.9	58	19.1	58
501-1000 Pula	31.6	80	25.3	77
1001-2000 Pula	20.6	52	23.7	72
2001-5000 Pula	12.7	32	20.7	63
5001-10000 Pula	10.3	26	9.9	30
10000-20000 Pula	1.2	3	1.0	3
20000 or more Pula	0.8	2	0.3	1
Ever in an intimate relationship				
No	5.8	37	11.53	68
Yes	94.2	602	88.47	522
Currently in an intimate relationship				
No	24.4	149	22.28	123
Yes	75.6	462	77.72	429
Live with current partner				
No	47.6	219	48.84	210
Yes	52.4	241	51.16	220

Table 2.2 shows that 43% of women and 44% of men were aged 18-29 years. The majority of women (60%) and men (57%) did not complete high school. The sample was predominantly Batswana with 5% of foreign women and 3% foreign men.

The majority of women (59%) had not worked in the 12 months to the survey while the majority of men (53%) had worked in a similar period. The majority of women and men that worked in the 12 months to the survey earned less than P5000 including benefits. Eighty eight percent of women and 89% of men earned less than P5000.

The majority of women and men have been in heterosexual intimate relationships. Ninety four percent of women and 88% of men said they had been in an intimate relationship. Ninety eight percent of women and 92% of men said they had sexual intercourse.

Administrative data



Women's Shelter Project in Gaborone. *Photo by Roos van Dorp*

GL gathered administrative data to document the extent of GBV as recorded in public services, namely the police, courts, shelters, health and counselling services.

The administrative data complemented the results of the prevalence and attitudes survey data. It is widely accepted that administrative data does not accurately provide information on the extent of GBV, more especially of intimate partner violence, mainly due to the high levels of underreporting.

> In the words of Sylvia Walby: ". . . it would be most unwise to treat such data as a guide to the actual level of violence in that if it were used as an indicator it might create a perverse incentive to minimise the amount of violence over time in order to suggest improvements".[26]

However, this data provides a basis for assessing the extent of under reporting, thus assisting in the areas that need improvement.

Speaking out can set you free: the *"I" Stories* experience

In 2004 GL started the *"I" Stories* project as a part of the Sixteen Days of Activism on Gender Violence Campaign. GL worked with women who had experienced violence, and men who used to perpetrate violence, to write their stories. These personal accounts were published in a series of booklets called the *"I" Stories.*

This study used the GL *"I" Stories* methodology to gather the experiences of violence against women as well as men's experiences of perpetrating violence - physical, sexual, psychological and economic abuse. GL Botswana identified survivors and perpetrators through support organisations providing GBV services.

[26] Walby, S, op cit.

Participants received examples of published *"I" Stories* so that they are aware of what the final product will look like.



Women and men were asked to write their personal experiences of violence. Participants submitted the first draft of writing to an editor, who edited the story and reverted to the writer for clarification. Once the story was in final draft form, the editors send the article to the writers to ensure that the editing had not resulted in a change of meaning or intention.

Violence against women

The stories from women survivors aimed to assist in identifying the following key research questions for violence against women:

1. Are women able to identify the various forms of abuse? (physical, sexual, psychological or economic)
2. How many women interviewed are experiencing the various forms of abuse?
3. What are the causes of violence against women?
4. What are the effects of violence against women? (physical, psychological, economic or social)
5. How does abuse impact on the ability of women to leave abusive relationships?
6. What support has been available for women experiencing abuse?

Perpetration of violence against women

In order to understand perpetration of violence against women and inform rehabilitation programmes, known reformed perpetrators of violence against women were identified through support organisations. Key research questions for perpetrating violence against women included:

1. What forms of violence (physical, sexual, psychological or economic) do men perpetrate?
2. What are the causes of violence against women?
3. What brought about the reformation?
4. What support has been available for perpetrators of violence?

Ethical considerations

Researchers:

- Informed participants how their stories would be used and distributed.
- Gave participants the option of using a pseudonym and not revealing their identities.
- Asked participants to sign off the final versions of their stories and approve any changes or revisions.
- Obtained permission from participants before forwarding stories to the media.

In this study GL worked with the Women Against Rape, Chobe District and Selibe Phikwe Councils. The partners mobilised the 25 women and 10 men that attended writing workshops and told their stories. The women and men who submitted their stories asked not to be named. The writers chose pseudonyms. At their request, their photographs have not been used.

Media monitoring

The GL Gender and Media Progress Study launched in 2010 covered the nature and extent of GBV coverage in Botswana. This project analysed GBV content in the media over a period of one month. The media monitoring on GBV assessed the extent of GBV coverage, sex of sources, topics covered, depiction of survivors, and sex of the reporters.

The study sought to answer the research questions outlined below.

- What topics are given the most and least coverage in the media?
- What proportion of coverage is specifically on GBV?
- What proportion of coverage mentioned GBV?
- How do media houses in each country compare with each other in their coverage of GBV?
- Of the coverage on GBV, what proportion is on prevention, the effects on victims and others, support and response?
- How do the GBV topics further break down into sub-topics?
- What is the overall breakdown of genres (news and briefs, cartoons, images and graphics?
- Editorial and opinion, features and analysis, feedback, interviews, profiles and human interest.
- How does GBV coverage break down with regard to these genres?
- Where do the stories come from (international, regional, national, provincial, local)?
- How does GBV coverage break down with regard to origin of stories?
- On average, how many sources per story are there on GBV stories?
- On average, how many stories indicate the connection between GBV and HIV and AIDS?
- Overall, what is the proportion of women and men sources?
- How do individual media houses in each country compare with regard to male and female sources?
- What is the breakdown of women and men sources in the stories about, and stories that mention, GBV?
- What is the breakdown of women and men sources in the further breakdown of the GBV topic category into prevalence, effects, support and response?
- In the case of GBV sources, what proportion are persons living with HIV and AIDS, persons affected by HIV and AIDS, traditional or religious figures, experts, civil society, official and UN agencies or other?



Botswana Television Journalist covering discussion on the role of men in Gaborone, December 2010. *Photo: Vincent Galatlhwe*

Research tools

The media monitoring combined both quantitative and qualitative research methods. Monitors gathered quantitative data on the media's coverage of gender, HIV and AIDS and GBV. Team leaders in each country selected articles for further analysis to give more in-depth analysis to the quantitative findings.

Quantitative research

The quantitative monitoring consisted of capturing data on the media's coverage of gender, GBV and HIV and AIDS using a coding instrument. Data was captured into a database pre-designed for this research. Monitors had to capture a specified set of data from each item. This included information about the item itself, who generated or presented the story (presenter, anchor, reporter, and writer) and who featured in the item.

The process included:

- Filling in standard forms each day for each item monitored with the assistance of a user guide prepared by GL;

- Submitting forms for checking to the team leader who generally monitored at least one medium to better understand any difficulties that the monitors encountered;
- Entering of data into a database;
- Quality control by GL;
- Delivery of the database by e-mail to GL to be synthesised into one central database that has made possible this regional overview report, as well as country comparisons with regional averages; and
- Data analysis and generation of graphs.

> "The views and attitudes articulated by political leaders have a strong influence on public opinion."

Qualitative research

After the quantitative monitoring, articles were selected for further analysis to give more in depth analysis of the quantitative findings. These case studies highlight best practices in the coverage of gender, HIV and AIDS, GBV as well as areas that need to be improved. The case studies serve to further elaborate and support many of the observations made in the quantitative analysis and answer the following questions:

- How are women and men labelled as sourced in the media?
- Is there a good balance of men and women sources? Do women and men speak on the same topics, or do media reserve specific topics for men only and specific topics for women?
- Does the language promote stereotypes of men and women?
- Are physical attributes used to describe women more than men?
- How are women portrayed in the story? How are men portrayed in the story?
- Are all men and women in a society represented and given a voice in the media?
- What are the missing voices, perspectives in the story?
- What are the missing stories?

Political content analysis

The views and attitudes articulated by political leaders and communities have a strong influence on public opinion. To measure the prevailing GBV discourse articulated by political leaders, GL analysed 188 speeches over a two year period to assess the extent, understanding and commitment to GBV.

The study accessed speeches from the government website, websites of different ministries, BOPA News, Mmegi online and Information services archives for the period from 2009-2011. The study only analysed official written speeches, records of Parliament debates or press releases.

Triangulation

Table 2.2: Project components and tools used to gather data

RESEARCH TOOL/ INDICATORS	Prevalence and attitudes survey	Adminis-trative data	*"I" Stories*	Media monitoring	Political content analysis
Extent	✗	✗	✗		✗
Effect	✗		✗		
Response	✗	✗	✗	✗	✗
Support	✗	✗	✗	✗	✗
Prevention	✗		✗	✗	✗

Table 2.2 shows how these tools inter-relate and how the research uses them to triangulate findings throughout the research to answer the key questions relating to extent, effect, response, support, and prevention. The flagship tool is the prevalence/attitude study, justified on the basis that statistics obtained from administrative data do not cover many forms of gender violence, and even those that are covered are under-reported. However, the *"I" Stories*, or lived experiences, give a human face to all aspects of the research. The administrative data, media monitoring and political content analysis provide key insights in relevant areas. Triangulation helps to verify and strengthen the findings, as well as provide key insights for policy-making and action planning.

CHAPTER 3
Extent of GBV



Participants at a march against GBV organised by Women's Affairs Department during Sixteen Days of Activism in Gaberone, Botswana. *Photo by WAD*

Key facts

- ✓ Of all women interviewed in the study, 67.3% had experienced some form of GBV in their lifetime. 44.4% of all men said they perpetrated some form of violence.
- ✓ The term Intimate Partner Violence or "IPV" in this study describes physical, sexual, economic or emotional harm by a current or former partner or spouse.
- ✓ The most common form of GBV experienced by women is IPV with 62.3% women reporting lifetime experience and 47.7% of men disclosing perpetration.
- ✓ The most common form of IPV is emotional followed by physical, economic, and sexual violence.
- ✓ Almost equal proportions of women (11%) said they had experienced, and men (10.7%) said they had perpetrated rape in their lifetime.
- ✓ Of all the women interviewed, 16% experienced attempted rape while 2.2% of the men in the sample disclosed attempted rape of a non-partner.
- ✓ Almost a quarter of women who were ever pregnant (24%) experienced abuse during their pregnancy.
- ✓ Almost a quarter (23%) of all the women interviewed said they had experienced sexual harassment at school, work, in public transport or at the healer's.
- ✓ Only 4.7% of women who experienced physical abuse and sustained injuries through an intimate partner sought medical attention, and 7.1% reported the abuse to the police.
- ✓ 9.9% of all women experienced being forced to have sex with someone who was not their partner and 4.9% of the men said they had done this.
- ✓ Only one in nine women raped reported this to the police. One in seven women reported the rape to a medical professional.



"I (Hare[27]) had just finished my course in hotel and catering management when I found a job in one of the Safari camps as a chef. That is where I met Jobs, my husband in 1999. We fell in love at first sight. He was working as one of the camp managers there. Three months after I joined the camp, Jobs left work and went back to town. Despite the long distance between us we kept in touch.

In 2000, when I was on leave we got married. I had my first child and the relationship was fine until we expected the second child. It was then that the relationship became sour. At that time I was still at the camp.

In the camp, families were not allowed to stay if they had two children. I therefore asked my mother in-law to remain with our two children but she said could not make it due to her old age. Having these problems I ensured that I saved money to build a house at our plot. I left the camp after the completion of the house and opened a small tuck-shop at home to earn a leaving.

Suddenly my husband started coming home late. My husband would not eat the food we prepared. He would sleep with clothes and when I tried to talk to him he would get angry. I then decided to keep quiet. Life continued like that until 2003 when my husband instructed me to go home promising me that he will visit the children and I.

When I left, he only gave me money for transport but nothing for our children to be taken care of. While we were at home my husband never phoned or sent money. He never visited. When the kids got sick he never cared. While we were at home our clothes got stolen and we informed him but he never cared or responded. I then decided to move from home to go back to him.

We arrived at home late in the night. On arrival my husband did not welcome us, rather he instructed me not to sleep in the bedroom. He made me sleep in the unfinished sitting room. Imagine the sitting room, without windows or door with the kids. As if it was not enough the following morning he packed all my things and took me to his mother where I fainted.

I woke up at the hospital. My children were taken to my mother in-law and were not taken care of properly. While these kids were at my mother in-law, their father never visited them. Surprisingly he went out of the country visiting his female friends.

When I came out of the hospital I could not take the abuse anymore. I stayed with my aunt in another town. I started looking for part time jobs to get money for the survival of my kids. I got a job as a chef in one of the hotels.

A month later, my husband returned only to take all his belongings from the house. I later found that he had a girlfriend and that they had a child together. I

[27] Not her real name.

remained alone with my children and since I had a job, I managed to finish our incomplete house and take care of my children. My husband never bothered to help me and his children.

A few months later, I was raped by a strange man while I was travelling. I found out I was pregnant. I informed my husband but he never cared. Since then I lived with shame, pain and was unproductive at work. This affected my job and I was fired from work. I gave birth to a baby girl as result from rape.

Later my husband decided to come back home. On arrival he apologised for everything and requested that we should give our marriage another chance. He promised to take care of the child born out of rape saying that it was not my fault that I was raped. My husband had lost his job and had nothing to bring home. It was a burden for me to feed him and the children.

A few months later he got a job and things started to change again, he even bought a car. He started coming in late at night and would tell me to take this other baby to her father. He said that the baby and I should leave his house, the built by me. He threatened to burn my baby and I.

Every day there was a story. One day he told me that he was going for a wedding where he stayed for five days and when he came back he took all my clothes and those of the children and threw them outside.

I phoned my pastors who came that night. They tried to talk to him but he could not listen. He just emphasised that he cannot stay in the same house with the baby and I. He then took everything in the house including the TV, fridge, I mean everything and he said he was moving to his mother's place.

My pastors talked to me and gave me courage. They referred me to Women against Rape (WAR) for help. At WAR I got help for emotional, mental and physical abuse. WAR provided me with me a short course in business management. I have now started a small catering business with some cash from my pastors. My husband wanted to come back home, I do not want anything to do with him. I told him that we should first go for marriage counselling and HIV and AIDS test but he refused. He tried to force me to have sex with him, I never allowed him. He ended up beating me saying I have a boyfriend. I have now filed a divorce with the help of WAR. I hope I will be happy and free from this man. Currently, the children are happy and my business is doing well."

Hare's story is an example of how women can face multiple incidents of the different forms of GBV. Hare experienced emotional, economic and sexual IPV. Her husband evicted her from the matrimonial home and did not give her money for household use.

She suffered in many ways including being hospitalised as a result. She had an unplanned pregnancy when she was raped which became a cause of conflict in her marriage. Her experiences of IPV heightened whenever her husband became economically stable.

Despite her negative experiences Hare picked herself up and worked towards economic independence. She became independent she was able to file divorce and support herself and her children. This chapter presents the findings of the prevalence study on the extent of GBV.

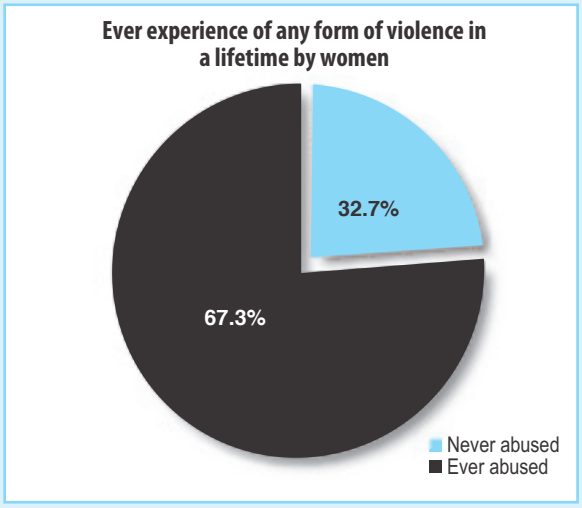


Gaborone Youth Singers launch the GL Botswana office and the research study. *Photo by Roos van Dorp*

GBV in a lifetime

This study measured both the lifetime prevalence of GBV and prevalence in the 12 months prior to the survey. The study derives lifetime prevalence from whether the respondent admitted to ever experiencing or perpetrating any one of the acts of GBV.

Figure 3.1: Any experience of GBV by women or perpetration of GBV by men



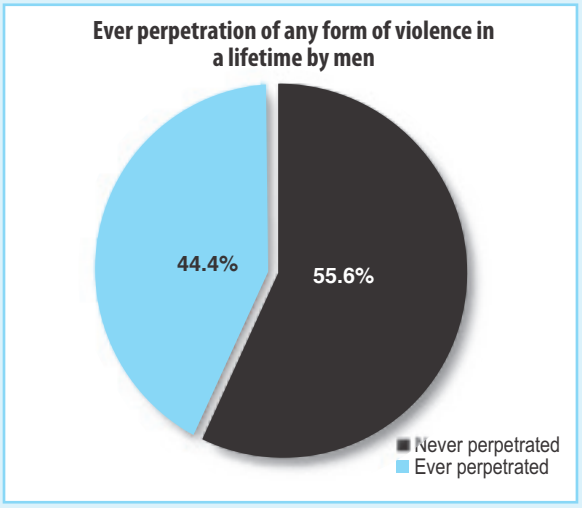


Figure 3.1 shows that 67% of all women recruited in the study had experienced some form of GBV in their lifetime, while 44% of all men admitted that they perpetrated some form of GBV in their lifetime. In the Gauteng province of South Africa 51% of all the women in the sample experienced some form of violence in their lifetime while 75% of men said they had perpetrated GBV at least once in their lifetime.

> "Through whichever prism one views these results they reflect exceptionally high levels of GBV in Botswana."

While high, the proportion of women who reported experiencing violence in a lifetime in Gauteng is significantly lower than in Botswana. The opposite is true for men in the sample in Gauteng and Botswana. The fact that men in Botswana are less likely than elsewhere to admit to violent behaviour has important policy implications; they may not even be aware themselves that their behaviour is violent. At the same time, the fact that nearly half the men in Botswana admit to behaviour reportedly experienced by two thirds of the women surveyed points to a degree of corroboration. Through whichever prism one views these results they reflect exceptionally high levels of GBV in Botswana.

Figure 3.2: Forms of violence experienced and perpetrated in a lifetime

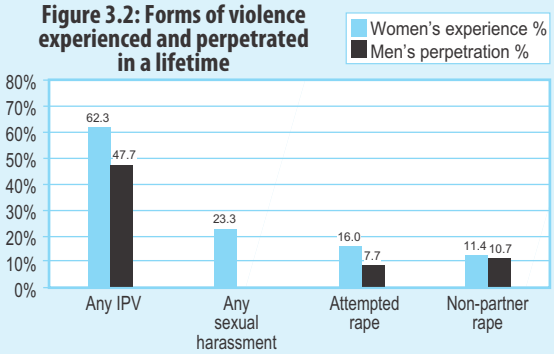


Figure 3.2 shows that the most common form of GBV experienced by women and perpetrated by men is Intimate Partner Violence or IPV. Sixty two percent of ever partnered women in this study experienced some form of IPV at least once in their lifetime. Forty eight percent of the men interviewed admitted to perpetuating IPV at least once in their lifetime.

Sexual harassment ranked second. Of all the women interviewed, 23% experienced some form of sexual harassment at least once in their lifetime.

Attempted rape ranked second and non- partner rape fourth. Sixteen percent of women said a non-partner had unsuccessfully tried to rape them, while seven percent of the men said they attempted to rape a woman who was not their partner but did not succeed in doing so. An equal proportion of women and men (11%) reported experiencing and perpetrating rape respectively.

IPV

The term Intimate Partner Violence or "IPV" in this study describes physical, sexual, economic or emotional harm by a current or former partner or spouse.

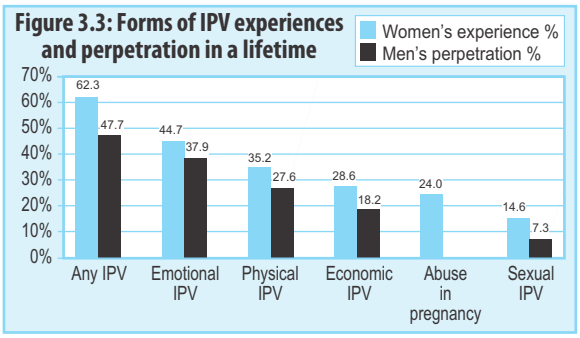


Figure 3.3 shows the prevalence of IPV experienced by women and perpetration by men. Consistent with findings in Gauteng, emotional violence ranked highest, followed by physical, economic, abuse in pregnancy and sexual IPV. In all instances, women reported a higher level of experiencing these forms of violence than men admitted to perpetrating these forms of violence. This shows a high level of awareness on the part of women which is a positive sign. The fact that there is a high level of corroboration by men saying they perpetrated these forms of violence also validates the results.

Emotional IPV

In this survey, emotional abuse was assessed by six questions which asked about experience (or perpetration) of a series of different acts that were controlling, frightening, intimidating or undermined women's self-esteem. Women participants were asked if a male partner had ever insulted them or made them feel bad; belittled or humiliated them in front of other people; threatened to hurt them; stopped them from seeing friends; done things to scare or intimidate them; or boasted about or brought home girlfriends. Men were asked if they had done any of these things to a female partner.

Forty five percent of ever partnered women experienced, while 38% of ever partnered men perpetrated, emotional IPV at least once in their lifetime.

These findings are similar to the Gauteng study where 44.7% women reported emotional violence. In Gauteng, however, higher proportions of men (65%) disclosed perpetration. Emotional violence is often the backdrop for physical and sexual violence.

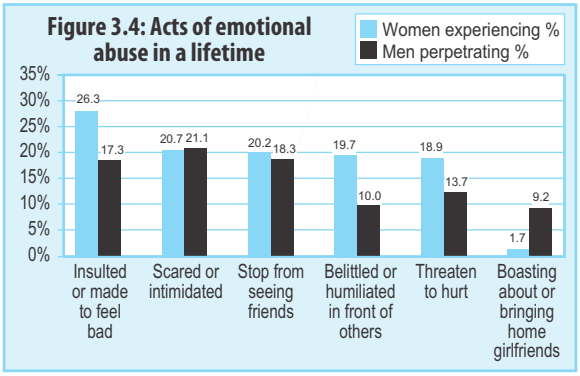


Figure 3.4 shows the prevalence of different types of emotional abusive acts experienced by women and perpetrated by men in their lifetime. The most common form of emotional abuse is men insulting

women or making them feel bad. Twenty six percent of ever partnered women experienced while 17% of ever partnered men had done this.

Being scared and intimidated ranked second: twenty one percent of women reported being scared or intimidated at least once. An almost similar proportion of men admitted to scarring or intimidated their partners at least once in their lifetime.

Mmatswii* wrote about her experience of emotional violence, "Sometimes after we got married he started coming home in the early hours of the morning, singing so loud that the children would wake up.

He then started bringing other ladies during the night, and used the other room that we were not using. What he would do is take a blanket from our bed while I was asleep to use it with his ladies.

He had given away most of the blankets and collected money from those I had given credit to and used it to feed his ladies in hotels while we starved.

When his friends from work came over, he would laugh and tell them how bad I was in bed, that I am not marriage material and that he married me out of pity since nobody in his right mind would look at me twice.
**Not her real name.*

One in every five women that had been in a relationship reported being stopped from seeing friends, belittled or humiliated in front of others by their partners at least once in their lifetime. A similar proportion of women reported men threatening them with violence.

Two percent of women had partners that had boasted about or brought home girlfriends.

A greater proportion of men reported scaring their partners and boasting about or bringing home girlfriends compared to the proportion of women reporting experience.

Economic IPV

Acts of economic IPV in this study include withholding money for household use, prohibiting a partner from earning an income, taking a partner's earnings or forcing a partner and children to leave the house in which they were staying.

Economic violence featured as the third most common form of IPV experienced by women and perpetrated by men. Overall, 29% of women experienced economic abuse and 18% of men disclosed perpetration.

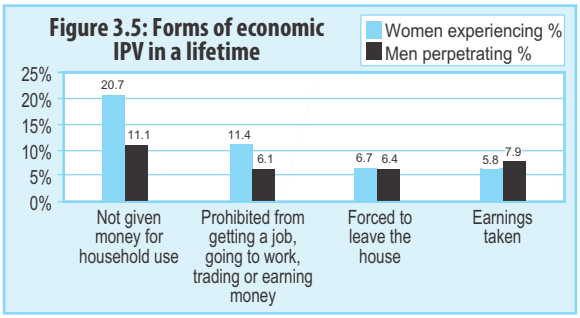


Figure 3.5 shows the proportions of women experiencing and men perpetrating the different acts of economic IPV in their lifetime. The most common act of violence experienced by women is not being given money necessary to run the household when this money was available. One in five ever partnered women said to have experienced this, while only 11% of men admitted that they had done this. Eleven percent of women were prohibited by their partner from getting a job or participating in income generating activities. Six percent of men admitted that they prohibited their partners from getting a job, or earning an income.

Seven percent of women disclosed that they were forced to leave the house in which they were staying like in the story of Milly at the beginning of this chapter. A similar proportion of men admitted that they had forced a partner out of the house.

Six percent of women that had ever earned an income reported that their earnings had once been taken away by their male partners. Eight percent of men said they had once taken a partner's earnings.

Physical IPV

The second most common IPV form is physical IPV. Experience of physical IPV in this study was ascertained by asking five questions about whether women had been slapped, had something thrown at them, were pushed or shoved, kicked, hit, dragged, choked, beaten, burnt or threatened with a weapon.

Kebogopole* said, "I got into trouble and lost all my property because of the debts that my husband had entered into. When we got married I had asked him to declare all his debts but he denied having any debts.

I don't know what made me believe him so easily. I ended up cleaning up my savings to clear the debts since we were married in community of property. Then I realised it was time to get out of this marriage, but other people advised me not to. I just continued with that situation. I later realised that it would have been better if I had not gotten into this marriage."
**Not her real name*

Thirty five percent of ever partnered women in the study experienced physical IPV while 28% of the men perpetrated physical IPV at least once in their lifetime.

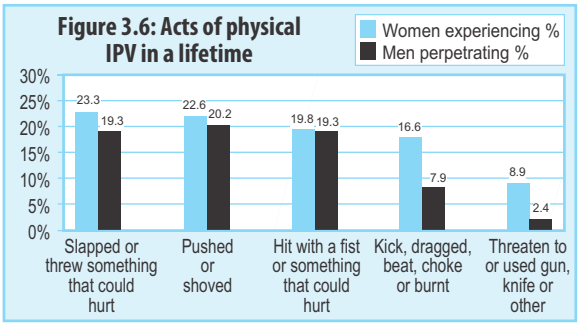


Figure 3.6 shows the different acts of physical abuse disclosed in the survey. For all acts of physical IPV a higher proportion of women reported experiencing this form of violence than the proportion of men reporting perpetration. Twenty three percent of ever partnered women were slapped, or had something dangerous thrown at them, while 19% of men admitted to ever doing this. Twenty three percent of women were pushed or shoved while 20% of men admitted to having pushed or shoved a partner at least once.

Wanisa* said, "On another day he took an axe and wanted to kill. I ran to the police and reported the matter but the police told me to go back home. They told me to only come and report if he cuts me. This has not happened once or for two months but several times. So I am tired. Last year in August we started taking ARV tablets since we are HIV positive.

My husband does not allow me to sweep the yard, to fetch firewood, to go to the shops, to have friends. He says I should only stay inside the yard as he suspects that I am involved in prostitution. But I have not had a boyfriend, ever since I came to Botswana. So please help me, what should I do! When I went to look for a place to stay so that I separate from him he followed me there, shouted at me and broke the window of the house and also beat me up."
**Not her real name.*

Almost similar proportions of women and men reported being hit or hitting with a fist or something harmful. Twenty percent of women experienced while 19% of men experienced this. Seventeen percent of women said that men had kicked, dragged, beaten, choked or burnt them; 8% of men admitted to this. Nine percent of women said they had been threatened with a gun, knife or other harmful weapon; two percent of men admitted to this.

Table 3.1: Frequency of physical IPV		
Frequency	**Women's experience %**	**Men's perpetration %**
Never	65.1	72.4
Once	23.1	17.2
More than once	11.8	10.3

Table 3.1 shows that the majority of acts of physical IPV reported in this study by both women and men were once off acts. Two in every three women that reported ever experiencing acts of physical IPV had experienced it on one occasion. An almost similar proportion of men (62%) who perpetrated physical IPV had done so on one occasion.

Sexual IPV

The study assessed sexual IPV experienced by women using three questions. These covered: if their current or previous husband or boyfriend had ever physically forced them to have sex when they did not want to; whether they had had sex with him because they were afraid of what he might do and whether they had been forced to do something sexual that they found degrading or humiliating.

Maritha* was deserted by her partner after she became pregnant at the age of 40. After separation her partner who had other sexual partners still comes back demanding unsafe sex. She said, "I am now HIV positive and he is also HIV positive. He does not want to use any condoms yet he has many girlfriends. He is currently staying with a woman who is always provoking me."
*Not her real name

Fifteen percent of ever partnered women experienced while seven percent of ever partnered men perpetrated sexual IPV at least once in their lifetime.

[28] Not her real name.

Table 3.2: Frequency of sexual IPV		
Frequency	**Women's experience %**	**Men's perpetration %**
Never	85.4	92.7
Once	6.8	3.8
More than once	7.8	3.4

Table 3.2 shows that a higher proportion of women encountered sexual IPV on multiple occasions than experienced this only once.

Galebolelwe[28] spoke of how her partner forced her on different occasions to have unsafe sex. "After getting drunk he would force me into having unprotected sex with him despite my advice on protected sex. He would sometimes call me degrading names when I tried to caution him on his behaviour. I remember one day when he wanted to have sex with me and when I refused he said '...you poverty founded moron, don't you know that I do as I please with you?' My relationship was dysfunctional, full of distress and bitterness. The culprit seemed to enjoy my lamentations."



Rachel Jeremiah, Chobe Council Secretary, at the Gender Justice and Local Government summit preliminary briefing workshop in Botswana. *Photo by Roos van Dorp*

Abuse in pregnancy

Experience and perpetration of IPV may be provoked or increased by pregnancy. This may be due to a longstanding abusive relationship that continues after a woman becomes pregnant. It may also be prompted by various reasons such as unintended pregnancy or suspicion of birth control sabotage.

Cindy* writes, "We were staying together happily. When I was five months pregnant with the second child I started going to night clubs and bars. At first I thought he wanted to interact with others and took it lightly.

It became a routine thing until I started questioning his movements. When I confronted him he did not like it and got annoyed, I thought maybe its the way I was talking to him. He did not like to be confronted especially with things he liked, if you criticise him he becomes defensive.

I was stressed because I was pregnant and had a 15-month-old child. I started shouting at him. He refused to make love to me. After a while he started sleeping out. He would come home, wash, change his clothes and leave."
**Not her real name.*

The study explored the occurrence of IPV behaviour towards pregnant women by asking if women experienced acts of abuse during any of their pregnancies.

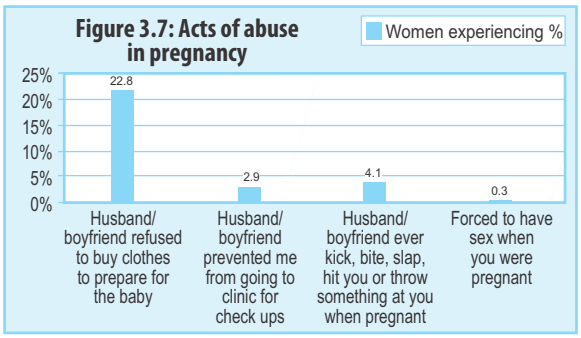


Figure 3.7 shows the proportions of women who experienced different acts of abuse during their pregnancies. The refusal by partners to buy clothes to prepare for the baby ranked highest (22%). Four percent of women reported men physically abusing them during pregnancy. Three percent said men prevented them from visiting the clinic for antenatal care. Three in every thousand women reported men raping them during their pregnancy.

Non-partner rape

The study assessed rape of women by men by asking three questions. These covered: whether a man not a husband or boy friend forced or persuaded the women to have sex against their will; whether they had been forced to have sex with a men when too drunk or drugged to stop him, and whether men forced the women to have sex with more than one man at the same time. The latter is an indicator of gang rape.

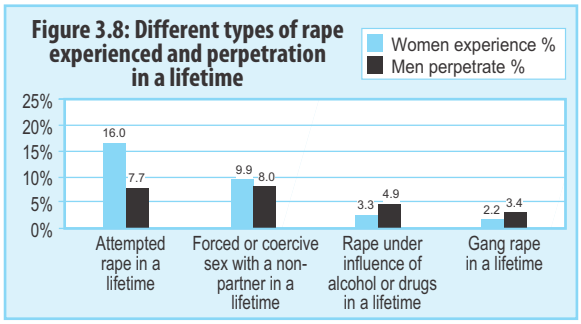


Figure 3.8 shows the different types of rape reported by women. About one in every ten women interviewed said they were forced to have sex with someone who was not their partner while one in thirteen men disclosed perpetration. Three percent of women were raped under the influence of drugs and 5% of men admitted to raping a non-partner when she was too drunk or drugged to consent. Two percent of women were gang raped while 3.4% admitted to participating in gang rape.

In Gauteng 25% of women had an experience of being raped by a man, whether a husband or

boyfriend, family member, stranger or acquaintance while an even higher 37.4% of men admitted to ever raping a woman. Overall, 18.8% of women experienced intimate partner rape on one or more occasions, a figure nearly identical to the proportion of men disclosing perpetration.

Sixteen percent of women said a man who was not their partner had attempted to rape them but had not succeeded in doing so. Eight percent of men had attempted to rape a non-partner.

Frequency of non-partner rape

The questions on rape were phrased such that the respondent provided information on the frequency of occurrence of incidents. Respondents could indicate whether they had been raped on one occasion or on two or more occasions.

Table 3.3: Frequency of non-partner rape and attempted rape

	Women's experience %	Men's perpetration %
Any non-partner in a lifetime		
Never	88.6	89.3
Once	7.0	4.9
More than 1 time	4.4	5.8
Attempted rape in a lifetime		
Never	84.0	92.3
Once	10.2	3.6
More than 1 time	5.8	4.1

Table 3.3 shows that the majority of women experienced one incident of rape and attempted rape while the majority of men that had raped had done so on more than occasion. Similarly 53% of men that attempted to rape had done so on more than one occasion.

Sexual harassment

According to the SADC protocol on gender and development sexual harassment means any unwelcome sexual advance, request for sexual favour, verbal or physical conduct or gesture of a sexual nature, or any other behaviour of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation to another whether or not such sexual advance or request arises out of unequal power relations.

Women participating in this study were asked about experiences of sexual harassment in the workplace, schools, whilst using public transport and when seeking help from traditional healers.



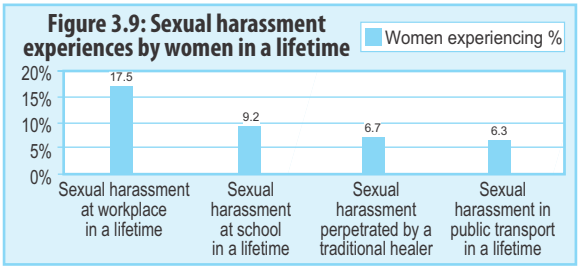


Figure 3.9 shows that 18% of women who had ever worked in their lifetime experienced sexual harassment in the workplace. Nine percent of women who had attended school were sexually harassed at school and 7% of all women that ever consulted traditional healers had been sexually harassed by a traditional healer. Six percent of women experienced sexual harassment whilst using public transport.

The dominant social and cultural norms in Botswana perpetuate rather challenge GBV. These values and beliefs need to start changing at a very early age. Schools, churches, the media and other relevant stakeholders have to start challenging the patriarchal value system to raise awareness and promote behaviour change.

The extent of reporting physical IPV and rape to medical health facilities was similar. One in seven women that were raped in their lifetime said they had sought medical attention.

GBV in past 12 months

Women and men were also asked whether their experiences or perpetration of GBV had occurred in the 12 months prior to the survey.

Figure 3.10: Experience or perpetration of GBV in past 12months

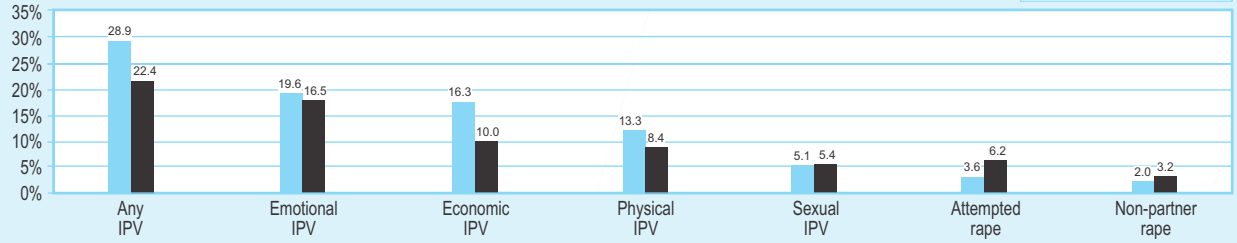


Figure 3.10 shows the experience by women or perpetration by men of GBV in the past 12 months before the survey. Overall, 29% of women experienced while 22 % of men perpetrated GBV in the 12 months before the survey. Emotional IPV was most common followed by economic IPV then physical IPV. Four percent of women experienced attempted rape while six percent of men had attempted to rape over the last year. Two percent of women reported non-partner rape while three percent of men said they had raped a woman in the 12 months before the survey.

"...it is apparent that most women survivors do not report to police or seek medical help."



Prevalence Study researcher conducting an interview during the research training in Mogoditshane.
Photo by WAD

Conclusion

The survey findings show that GBV, particularly IPV is a serious problem in Botswana. Both the prevalence of experience reported by women and perpetration by men confirm this. However, men do not admit to perpetrating as much violence as women say they experience.

Despite the high extent of GBV, experience reported by women in the study, it is apparent that most women survivors do not report to police or seek medical help. This finding is evidence for the need to rely less on police statistics as a source of information on GBV and to invest in regular household prevalence surveys. Surveys give more accurate and reliable information on the extent of GBV in a population. The collection and analysis of police statistics need to be reviewed, and strengthened.

CHAPTER 4
Patterns and drivers of GBV



Women speaking out at a meeting with local community in New Xade, Ghanzi District . *Photo by Keabonye Ntsabane*

Key facts

- ✓ Women in the 18-29 age group reported the highest lifetime IPV , while women in the 45 years and above age group reported the lowest lifetime IPV.
- ✓ 88% of women and 66% of men reported being abused as children; most of this physical abuse. There is a correlation between experience of child sexual abuse and perpetration of physical or sexual IPV.
- ✓ A significantly greater proportion of men who drank alcohol in the 12 months to the survey were more likely to perpetrate IPV than men who did not drink alcohol.
- ✓ Eighty-three percent of women and eighty two percent of men agreed that women and men should be treated equally, but contradicted themselves (especially men) in their views on such questions as women obeying their husbands.
- ✓ Women and men participating in the study perceived themselves to be more progressive than their communities.
- ✓ The rhetoric of gender equality has been internalised, but this is not yet translating into reality. Women are beginning to understand and assert their rights, but men are not yet walking the talk.
- ✓ Despite GBV being the most flagrant violation of human rights in Botswana and Southern Africa only 6% of the speeches by politicians over the last year focused on GBV while 15% made some mention of the scourge.
- ✓ GBV constituted 5% of media coverage n a 2009 study; with women comprising only 26% of news sources.
- ✓ Perpetrators of GBV are three times more likely than survivors to be heard in the news in Botswana.



"I (Kefilwe[29]) am writing this story about gender based violence. This violence can take many forms. I got married to my husband in 1969. We were living happily without any problems. We were blessed with five children. In 1986 our marriage became sour and the love we used to share was no more.

My husband hardly stayed at home. He would go to work and not return until around 3 am. He would come home late at night, holding a beer in his hand and tell me that '... no matter where you go, you are still my wife'. He would start dancing until morning.

He continued to do this until I went again to see his parents to ask him whether I was now his girlfriend. He responded by saying that I was his wife. I continued to stay away from my matrimonial home. He did not provide for me and my children. I went to my mother in law to ask them to intervene but she never addressed the situation.

I went to the kgotla to ask the Chief to intervene in the matter but my husband never changed his ways. In 1994, one of my grandchildren passed away. My husband sent us away. We had to go and stay somewhere else for the burial of the child. He did not come to the funeral.

Once he left us on the 20 June and only returned on 18 August.

Sometimes when I went to our home to talk to him about the welfare of the children, he would close the door in my face and not talk to me. By that time we had six children, two boys and four girls. Two of our children are now deceased. My husband did not assist me with the burial of my children, especially our daughter who used to work at Mowana Lodge at the time of her death.

The management of Mowana Lodge assisted us with four thousand pula. My husband took the money and did not inform me. When I approach the Mowana Lodge management they told me that they had given my husband their contribution towards the burial. I heard that he used the money to buy cattle. I did not see those cattle before he died.

When my husband died, his sisters said that I was the only wife they knew and so I had to participate in his funeral. The family wanted me to wear mourning clothes. I refused to wear the mourning clothes because of the violence I suffered in this marriage.

When I got married to this man, he had a child from another woman. I raised this boy as my own. Now the same young man is accusing me of killing his father and taking his inheritance. That is the story of my encounter with gender based violence."

Kefilwe experienced emotional and economic abuse perpetrated by her husband. Her husband claimed to "own" her. She sought help from family and reported to the "kgotla". The family did not support her. Although the chief at the kgotla intervened, the husband still did not reform.

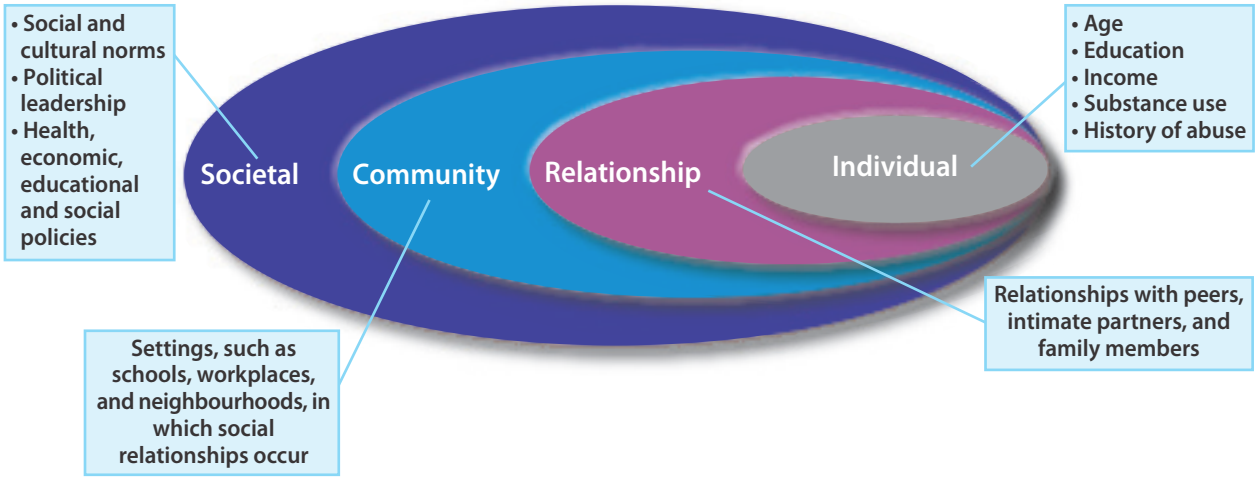
[29] Not her real name.

Kefilwe's husband forced her out of the matrimonial home and did not support her or the children. She remained married to this man until his death and the family expected her to participate in the mourning rites as the deceased's wife.

This story highlights the strong patriarchal value system that underpins relationships. Kefilwe's in-laws turned a blind eye to the way he abused her during his life but insisted she mourn his death!

The high levels of GBV are rooted in gender inequality and patriarchy. These are critical factors in all strategies to end GBV particularly in Botswana were the prevalence of GBV amongst women in the sample is so high. This chapter explores individual, family/ relationship, community and societal factors that impact on adult behaviours as shown by the ecological model framework. The chapter draws on the prevalence and attitude survey, as well as the political content analysis, to draw out the causes or drivers of gender violence in Botswana - both immediate and longer term.

Figure 4.1: The ecological model of factors associated with VAW



The ecological model in Figure 4.1 is used to explain why some of the violence occurs, why some men are more violent than others and why some women are consistently the survivors of abuse. Understanding the reasons for and the factors associated with experience or perpetration of gender violence is a precursor in the design of gender violence prevention interventions. The study investigated the association between the experience or perpetration of violence with individual, family, community and societal characteristics of participants. The study also explored social norms around gender relations.

Individual level factors

Individual level influences are personal factors that increase the likelihood of becoming a victim or perpetrator. Examples include socio-demographic factors, attitudes and beliefs that support IPV, isolation, and a family history of violence.

Socio demographic factors

Socio-demographic characteristics explored include age, education level and employment status.

Table 4.1: Socio-demographic factors associated with experience and perpetration of IPV								
Factors	**Ever IPV**				**Past 12 months IPV**			
	% women survivors	Chi(p)	% men perpetrating	Chi(p)	% women survivors	Chi(p)	% men perpetrating	Chi(p)
Age								
18-29	65.7	0.04	52.8	0.04	39.4	0.00	28.5	0.0001
30-44	65.7		48.6		30.8		26.0	
45+	54.3		38.5		9.2		8.1	
Level of education								
High school incomplete and lower	60.7	0.2	42.3	0.04	24.4	0.009	17.5	0.001
High school complete and over	65.8		54.7		35.8		29.2	
Worked in past 12 months				0.008		0.03		0.005
No	59.4	0.05	40.5		25.6		15.6	
Yes	67.6		53.7		33.6		28.1	

Table 4.1 shows that age, education and employment status in the 12 months to the survey were significantly associated with lifetime or past 12 months experience or perpetration of IPV ($p<0.05$).

Age

Table 4.1 shows that there is a statistically significant difference in the proportion of lifetime IPV survivors and perpetrators by age. The proportion of survivors and perpetrators of lifetime IPV decreased with age. Women in the 18-29 age group were most likely to report lifetime IPV while women in the 45 years and above age group were the least likely to report lifetime IPV. Men in the 18-29 and 30-44 years age group were more likely to perpetrate IPV in their lifetime compared to men in the 45 years and above age group. Similarly younger women and men in the 18-29 age group were most likely to report IPV experience and perpetration in the 12 months to the survey.

Education level

A greater proportion of men who completed high school perpetrated IPV in their lifetime and in the 12 months to the survey. Fifty five percent of men that completed high school perpetrated IPV in their lifetime. Twenty nine percent of men who completed high school perpetrated IPV in the 12 months to the survey.

A greater proportion of women that completed high school experienced IPV in the 12 months before survey. Thirty six percent of women who completed high school experienced IPV in the 12 months to the survey.

Employment status

Women who were employed in the 12 months before the survey were more likely to experience IPV in a similar period than women who were unemployed. About a third (34%) of women who were employed in the 12 months also experienced IPV in the same period.

Men who were employed in the 12 months the survey were more likely to perpetrate IPV in a similar period and in a lifetime. Fifty four percent of men who were employed in the 12 months prior to the survey perpetrated IPV at least once in their lifetime. Over a quarter (28%) of men who were employed in the 12 months before the survey perpetrated IPV in a similar period

Childhood abuse

Childhood experiences explored include childhood neglect, sexual and physical abuse. Participants in the study were asked about experiences of childhood neglect and abuse. Child abuse was ascertained

through a series of questions about forced sex, unwanted sexual touching, being severely beaten leaving marks and neglect by family, teachers or other community members.

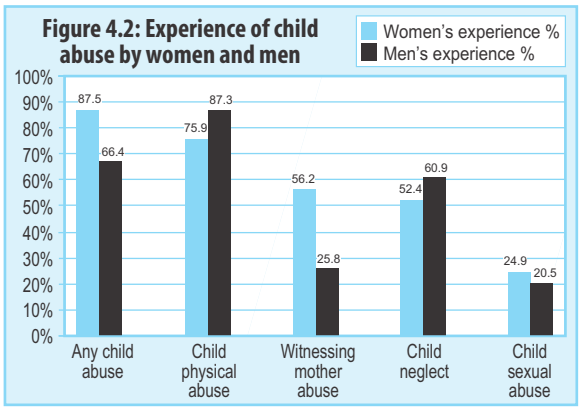


Figure 4.2 shows that the majority of women and men in this study experienced child abuse at least once in their lifetime. Eighty eight percent of women and 66% of men were abused as children. The most common form of child abuse experienced by women and men was child physical abuse whilst the least common form was child sexual abuse.

Child physical abuse

Child physical abuse was defined as ever experiencing an incident such as being beaten with a whip and left with a bruise or mark. This could have occurred at home, school or in the community. More men than women experienced child physical abuse. Seventy eight percent of women and 87% of men were physically abused before they turned 18.

Witnessing mother abuse

Participants were asked whether they had seen or heard their mother being beaten by her husband or boyfriend before they turned 18. More women than men reported experiencing this. Fifty six percent of women and 26% of men witnessed their mother being beaten.

Child neglect

Child neglect in this study included not being given enough food, parents being too drunk to care for their children, or children spending time outside the home without any adults aware where they were. More men than women experienced child neglect. Fifty two percent of women and 61% of men were neglected as children.

Child sexual abuse

Experiences of child sexual abuse were determined by asking participants whether they had ever been touched sexually or forced to touch someone, whether they had sex with someone of the opposite sex who was more than five years older, or whether they had been forced to have sex before they turned 18 years old. A quarter of women (25%) and a fifth of men (21%) had experienced some act of child sexual abuse.



Educating young girls and growing their confidence is key.
Photo by Vincent Galatlhwe

Kamabe[30] participated in the "I" story workshops and shared his experience of child sexual abuse.

[30] Not his real name.

"Now I know she (my half sister) was graduating from childhood into an adolescent and hormonal activities were at their peak, sexually. We had only one hut. She shared the same blankets with us.

I remember one night when I was fast asleep, I felt my half sister's hand fondling my genitals. I slept still and she later pinched me gesturing for me to obey. Young as I was, I believe she was 18 by then. She put me on top of her as she continued directing my penis that was erect into her moist birth canal.

I slept still and she continued pressing against me, later my pubic area was damp. I was filled with a mixture of excitement and confusion. She pinched me once again and pushed me away. This continued for months before I left for rural life.

In 1984 when I started school I was one of the most stupid pupils in my class. Full of complex questions that were too social and private for me to ask anyone, I remember as I grew up in the rural areas my cousins would tell me they were enjoying sex with older girls.

I could recall at the back of my head, "the moist thing". One day, I was introduced to the formalities of sexual activity. I was 11 years of age then. I was told by my cousin who was 18 years old by then that I only needed to buy them drinks. Failure to do that, I would give each of them 50 thebe which was equivalent to two cans. I stole my grand-mother's money and bought sex."

Child abuse as a risk factor for IPV perpetration

Experiences of abuse throughout life can influence an individual's inclination to engage in family violence either as a victim or as a perpetrator. We explored the link between child abuse experience by women or men and experience or perpetration of IPV in lifetime using chi square tests of association.

Table 4.2: Child sexual abuse as a risk factor to experience or perpetration of GBV in adulthood

	Any sexual IPV		Any physical IPV		Any rape	
	% women survivors	% men perpetrating	% women survivors	% men perpetrating	% women survivors	% men perpetrating
Experience of child sexual abuse	19.6	18.7	45.7	39.3	22.6	24.8
No experience of child sexual abuse	12.9	4.3	31.7	24.5	7.7	7.0
	p=0.06	p=0.000	p=0.02	p=0.02	p=0.000	p=0.000

Table 4.2 shows that experience of child sexual abuse is strongly associated with perpetration of physical or sexual IPV or rape later in life (p=0.05). A significantly higher proportion of male victims of child sexual abuse admit to being abusive: 19% of men sexually abused as children perpetrated sexual IPV compared to only four percent of men not sexually abused. Thirty nine percent of sexually abused men perpetrated physical IPV. A quarter of sexually abused men raped.

Women sexually abused in childhood were more likely to experience physical IPV and rape. Forty six percent of women sexually abused as children experienced physical IPV. 23% of women sexually abused as children experienced rape later in life.

Table 4.3: Witnessing mother abuse as a risk factor to experience or perpetration of GBV in adulthood						
	Any emotional IPV		Any physical IPV		Any rape	
	% women survivors	% men perpetrating	% women survivors	% men perpetrating	% women survivors	% men perpetrating
Witnessed mother being beaten by husband or boyfriend	52.1	48.8	41.2	45.0	14.2	18.6
Did not witness mother being abused by husband or boyfriend	35.6	34.7	28.2	21.6	8.4	8.6
	p=0.000	p=0.03	p=0.000	p=0.000	p=0.02	p=0.008

Table 4.3 shows a correlation between witnessing mother abuse and perpetration of emotional or physical IPV and rape. A greater proportion of women that saw or heard their mothers being abused, compared to those women that did not witness this, experienced emotional and physical IPV. Over half the women (52%) who witnessed mother abuse also experienced emotional IPV. About four in every ten women (41%) who witnessed mother abuse also experienced physical IPV. Fourteen percent of women that witnessed mother abuse experienced rape.

A greater proportion of men who witnessed their mothers being abused became abusive themselves. Forty nine percent of men who witnessed mother abuse perpetrated emotional IPV. Forty five percent of men that witnessed mother abuse perpetrated physical IPV. Nineteen percent of men who witnessed mother abuse raped.

Alcohol and substance use

This study explored the links between alcohol and substance abuse and GBV. Questions relating to alcohol and drugs included whether the respondent had taken alcohol in the 12 months to the survey and if the response was yes, then how often. Participants were also asked whether their current or most recent partner consumed alcohol and how often they did this. Questions on substance use included whether the respondent or their partner used drugs and how often they did this.



March against GBV by FBOs organised by Women's Affairs Department during the Sixteen Days of Activism in Gaborone, Botswana, 2011. *Photo by WAD*

Table 4.4: Alcohol consumption patterns by women and men		
	% Women	% Men
Have you drunk alcohol in past 12 months		
No	62.9	40.5
Yes	32.1	59.5
How often do you take a drink containing alcohol		
Monthly or less	55.7	39.7
2-4 times a month	23.5	28.2
2-4times a week	8.2	16.1
4+ times a week	12.6	16.1
More than 5 drinks on one occasion		
Never	31.9	16.6
Less than monthly	29.1	24.0
Monthly	25.8	31.8
Weekly	7.7	19.5
Daily or almost daily	5.5	8.1
Current partner alcohol frequency		
Every day/nearly every day	7.0	1.1
Only at weekends	19.4	8.9
A few times in a month	12.9	8.0
Less than once a month	9.2	6.4
Never drank	50.1	75.1
Stopped drinking	1.4	0.5

Table 4.4 shows that 32% of women and 60% of men in the study drank alcohol in the 12 months to the survey. The majority of women drinkers (56%) were occasional drinkers while 40% of men were occasional drinkers. Twelve percent of women who drank alcohol did so regularly. Sixteen percent of men drinkers drank regularly. Thirteen percent of drinking women were binge drinkers consuming more than five drinks weekly or almost daily. Twenty eight percent of drinking men were binge drinkers.

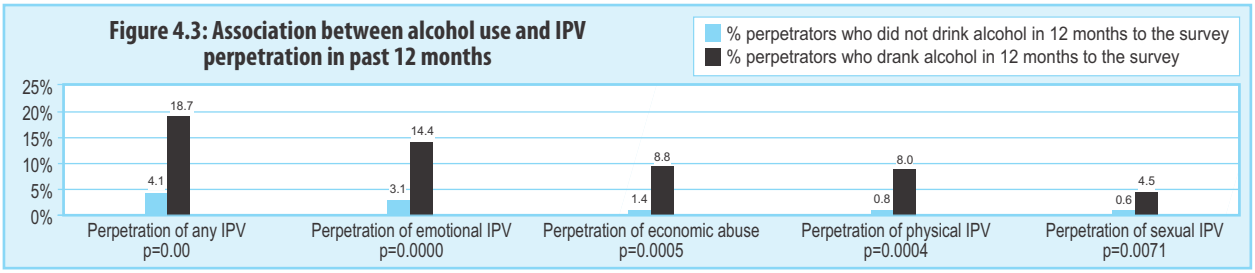


Figure 4.3 shows that a significantly greater proportion of men who drank alcohol in the 12 months to the survey perpetrated IPV than men who did not drink alcohol ($p<0.05$). Nineteen percent of men who drank alcohol perpetrated IPV in a similar period. Fourteen percent of men drinkers perpetrated emotional IPV in the 12 months prior the survey. Nine percent of men drinkers perpetrated economic IPV in the 12 months to the survey. Five percent of men drinkers perpetrated sexual IPV in the 12 months to the survey.

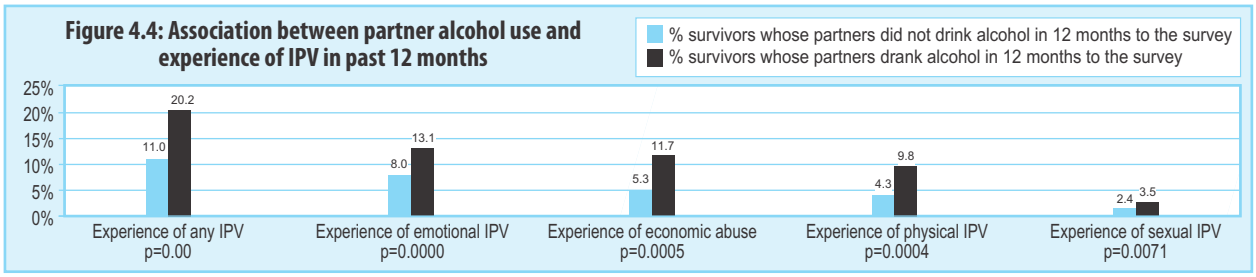


Figure 4.4 shows that having a partner who drank alcohol in the 12 months to the survey was associated with experience of emotional, economic and physical IPV.($p<0.05$). Thirteen percent of women whose partners drank alcohol experienced emotional IPV. Twelve percent of women whose partners drank alcohol experienced economic IPV. A tenth of women whose partners drank alcohol experienced physical IPV.

Galebolelwe* attributed her partner's abusiveness to alcohol abuse. She said, "He was 25 years old when I was only 18 years. He had the habit of drinking or he was a drunkard. After getting drunk he would force me into having unprotected sex with him despite my advice on unprotected sex"
** Not her real name.*

Experience of sexual IPV in the survey was not associated with whether a partner drank alcohol. However the women who told their stories like Galebolelwe mentioned that alcohol was a precursor to their sexual IPV experiences.

Drug use

The survey asked if participants had used dagga in the 12 months prior to the survey; also whether their partners had used drugs in a similar period.

Table 4.5: Drug consumption by women and men

	% Women	% Men
Used drugs in past 12 months		
No	97.7	84.0
Yes	2.3	16.0
Current or most recent partner drug use		
No	64.9	99.3
Yes	35.1	0.7

Table 4.5 shows that a greater proportion of men than women used drugs in the 12 months prior to the survey. Sixteen percent of men and two percent of women used drugs in this period. Thirty five percent of women had partners who used drugs while less than one percent of men had female partners who used drugs.

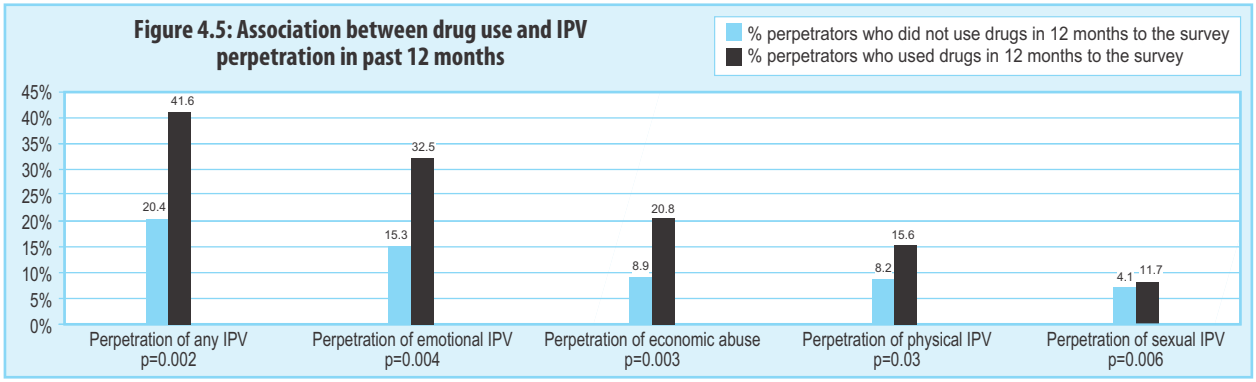


Figure 4.5 shows that a significantly greater proportion of male drug users perpetrated IPV in the 12 months to the survey compared to non-drug users. Use of drugs was associated with the perpetration of all four forms of IPV ($p<0.05$).Thirty three percent of drug users perpetrated emotional IPV. Twenty one percent of drug users perpetrated economic IPV. Sixteen percent of drug users perpetrated physical IPV. Twelve percent of drug users perpetrated sexual IPV.

Relationship factors

Relationship level influences are factors that increase risk due to relationships with peers, intimate partners, and family members. A person's closest social circle-peers, partners and family members-can shape an individual's behaviour and range of experience.

Infidelity within marriage is common in Botswana, where men are known to keep "small houses". "Small houses" are extramarital affairs resembling marriage, where the man has one or more girlfriends he is providing for and in some cases has children with[31]. Male infidelity in relationships is deemed acceptable based on the male's traditional role as the ultimate head of the household. Traditionally, women are not to question their husband's behaviour. It is a known societal norm that "a woman should never ask about her husband's whereabouts."

The broader society also views having multiple sexual relationships as a sign of successful manhood and masculinity. Often men do not use contraceptives in their multiple sexual relationships, which exposes the women to infection of STI's or HIV and AIDS.

Women participating in the study were asked whether they thought their current or most recent partner was having sex with someone else. We explored whether the probability of infidelity was a factor associated with women's experience of IPV in the 12 months to the survey.

Figure 4.6: Suspicion of infidelity associated with IPV experience

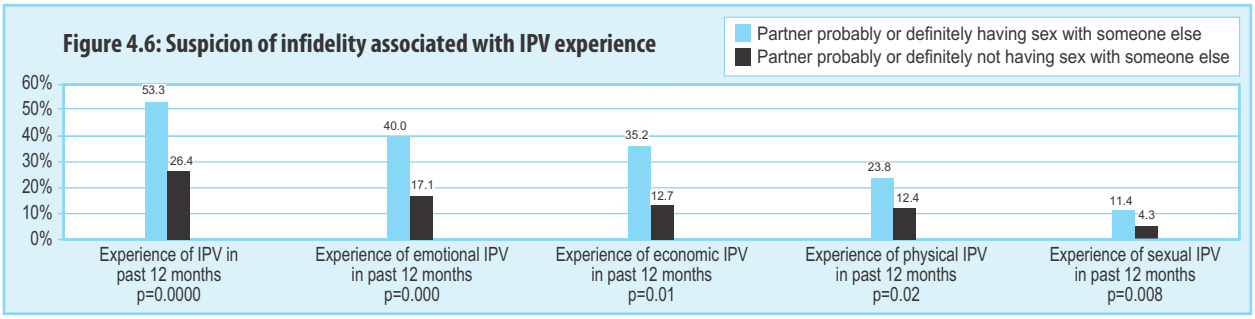


Figure 4.6 shows that women whose partners were probably or actually having concurrent multiple sexual partners were more likely to experience IPV in the 12 months to the survey compared to women whose partners were probably or definitely not.

These findings are supported by the stories told by women in this study. In most of the *"I" Stories* the women referred to another woman or girlfriend whom their partner had a sexual relationship with. Women often blamed their traumatic experience on the presence of the "other woman" in their partner's life. An example is Maritha's[32] story.

[31] UN 2009, Situation analysis on Gender-Based Violence in Botswana.
[32] Not her real name.



"I was a shebeen queen with a strong and powerful shebeen. At the age of thirty I first met my current boyfriend. I had four children and my last born was 8 years old. After staying with my boyfriend for three years, in January 1996, I fell pregnant. It was only then that he told me he had a woman in Nata who he had a son with. He planned to marry her because she had his first child. When I was four months pregnant he ordered me to stop coming to his place because his wife to be was preparing for marriage.

I stayed at my house where I was renting and doing my shebeen business. One of my landlords was sick of AIDS and later died. When he died I was accused of bewitching him to promote my business. I was then chased away from that place. I was given two hours to have moved out of their place. I struggled to find a place because I was labelled a witch, a person who poisons others. I finally got a place about four kilometres from town.

My boyfriend did not even bother finding me a place to stay yet I had spent my money helping him build his home of about seven houses before discovering that he had a wife. I even helped him connect water in his plot. People used to tell me that my boyfriend was once a lunatic, but I did not believe them.

In my new home there is no water so I fetch water at the river about a kilometre away from where I am staying. I gave birth to a boy, who is eleven years younger than his oldest brother. While pregnant, I was told that I needed specialists because I was almost 40 years old. I had a difficult delivery. My boyfriend did not bother helping in any situation.

But my son loves his father so much. He wanted me to stay with his father and has tried everything to bring us together. Sometimes he would go to his father's place after school and ask him to take him to where I live. His father would do so and even spent a night with us, but sometimes he would just drop him off and go back. This hurt the child because he wanted to live with his father. When schools closed, he would go and stay with him and return after three days to stay with me.

The father used to tell my son what he had bought for his child who is in Nata. My son would tell me and ask why his father did not care for him. I would tell him that I reported his father to the magistrate but his payments for maintenance were not consistent. The father would tell me to return the money so that he pays three or four times the same amount so that he covers the arrears to avoid going to prison. When I refused, he would say that he would commit suicide.

Up to now he still owes large amounts of money in court. He comes home any time he pleases. I am not comfortable bringing any other man because my children knew him from when they were young and they even know he is their father. I respect my children.

I am now HIV positive and he is also HIV positive. He does not want to use any condoms yet he has

many girlfriends. He is currently staying with a woman who is always provoking me. Whenever she meets my child she enquires if her 'husband' slept over at my place. Sometimes the man calls her telling her that he is at my place. Sometimes he can stay for about six months without coming over or even calling. That is when the woman 'challenges' me, laughing at me. The man usually comes over when there is commotion at their house.

What pains me the most is that it emotionally affected my child causing him to drop out of school while he was still young. I have tried to put him in different schools but still failed because if he goes to the father, the father sends him back to me. The other time he told my son that he was going to Nata to buy clothes for his other son. My son also followed him to Nata in a truck, hoping that when his father finds him there he will buy something for him.

I am now living under very painful circumstances because I do not have a proper home, no water, no toilet, no proper house but shacks, yet I built seven houses at his plot because he had promised to help me when I get my own plot. I am the only one in my area drinking water from the river, my son is not going to school because of stress, I am HIV positive, I do not have a boyfriend and I have a patella knee problem where he kicked me years back. I always pray that he leaves all his girlfriends to marry me or that he will go forever so that I will find a man of my dreams."

Maritha's partner deserted her after she became pregnant at the age of 40. After philandering with other women, he came back to her demanding unsafe sex. Maritha* is now HIV positive. She has also had to deal with the emotional harm to her son who is now a school dropout.

Galebolelwe* spoke of her husband who brought girlfriends home: "He then started bringing other ladies during the night, and used the other room that we were not using. What he would do is take a blanket from our bed while I am asleep to use it with his ladies. He had given away most of the blankets and collected money from those I had given credit to and used it to feed his ladies in hotels while we starved. When his friends from work came over, he would laugh and tell them to my face how bad I am in bed, that I am not marriage material and that he married me out of pity since nobody in his right mind would look at me twice."

Community factors

Community level influences are factors that increase risk based on individual experiences and relationships with community and social environments such as schools, workplaces, and neighbourhoods.

Attitudes towards gender relations

Previous research has shown that social norms that legitimise male dominance are key drivers of GBV. This prevalence and attitude study explored the personal attitudes of women and men and their perceptions of their communities' attitudes towards gender relations.



Culture is dynamic: Botswana delegates dancing at the cultural evening, Gender Justice and Local Government Summit. *Photo by Trevor Davies*

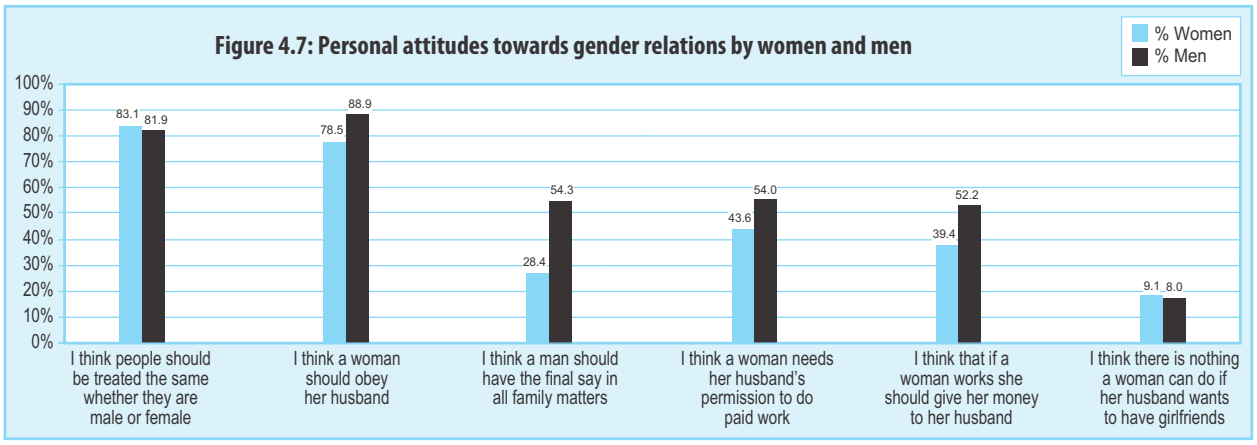


Figure 4.7 shows the personal attitudes of women and men toward gender relations. Eighty three percent of women and 82% of men agreed that women and men should be treated equally. Low proportions of women and men agree that: "there is nothing a woman can do if her husband wants to have girlfriends."

> "The rhetoric of gender equality has been internalised, but this is not yet translating into reality."

Yet almost 79% of women and 89% of the men in the sample strongly agree that a woman should obey her husband. Significantly high proportions of both women and men agree that a wife needs the permission of her husband to pursue paid work; also that a wife should hand over her income to her husband.

It is also significant that almost double the proportion of men (54%) than women (28%) believe that a man should have the final say in family matters.

These reflect a society in transition. The rhetoric of gender equality has been internalised, but this is not yet translating into reality. Women are beginning to understand and assert their rights, but men are not yet walking the talk!

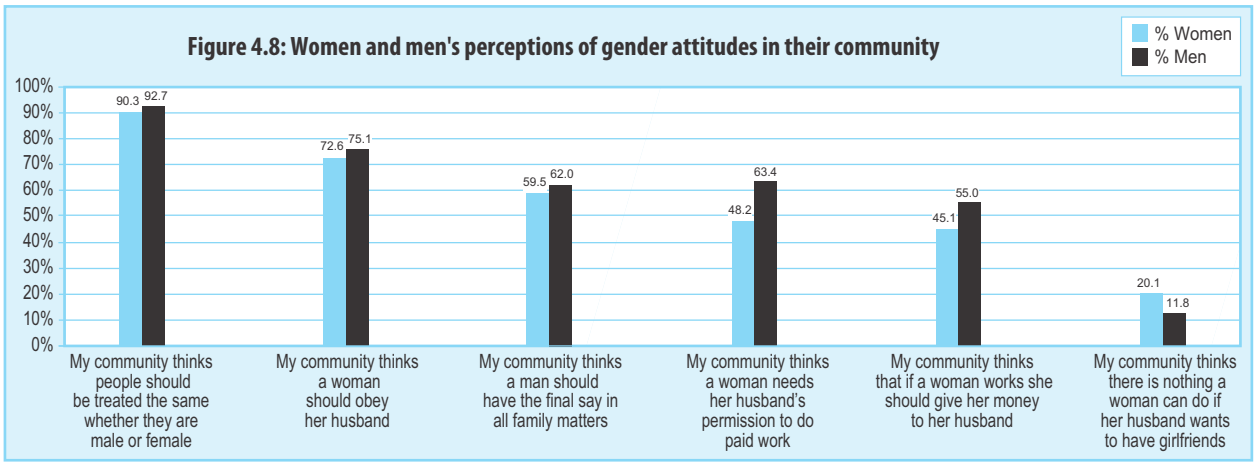


Figure 4.8 shows that generally both men and women perceived that their community held conservative attitudes towards gender relations. In fact a greater proportion of women and men perceived themselves to be more progressive than their communities on the notion of gender equality. Seventy two percent of women and 75% of men agreed that their community thought women and men should be treated equally. These proportions are considerably lower than the personal attitudes in Figure 4.7 where 83% of women and 82% of men agreed to the notion of gender equality.

Generally men perceived their communities to be more conservative than women. A greater proportion of men than women perceived that their communities expected men to have the final say, women to obey their husbands, to get permission for paid work and to hand over their income.

These findings point to a society that on the one hand has achieved a high level of economic growth, is a stable democracy and has high proportions of women in decision-making in the public and private sectors but where gender inequality has not been addressed in private spaces and in communities.

There is a need to better understand the factors leading to GBV such as socialisation, culture, religion, societal expectations, values and norms. This would assist in developing more targeted interventions. Further, it illustrates a lack of awareness and education about GBV especially in at local and community level.

Working and sensitising men to the impact of GBV on the lives of the women and children is critical. Engaging with men on how they can contribute to ending GBV is very important.

Sexual entitlement in marriage and legitimacy of violence

Sexual violence committed by men is rooted in societal norms that promote male sexual entitlement and limit women's options to refuse sexual advances. This is especially true when traditional norms regarding marriage demand women to always be sexually available to their husbands. In this study we explored personal and perceived attitudes around sexual entitlement.

Figure 4.9: Sexual entitlement in marriage and legitimacy of violence

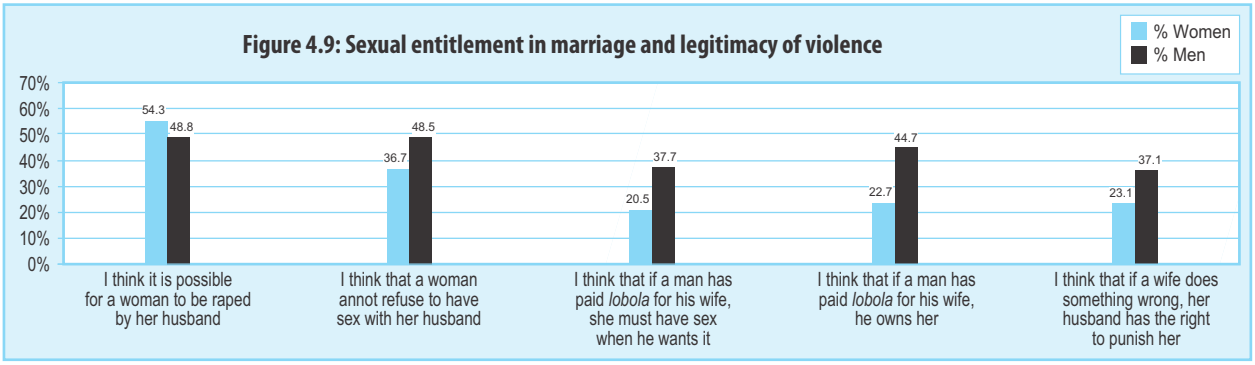


Figure 4.9 shows that a higher proportion of men than women hold conservative views on sexual entitlement and use of violence to control women. A greater proportion of men than women agreed that if a man has paid lobola, he owns his wife; she must have sex when he wants it and cannot refuse to have sex with him. In contrast, a greater proportion of women than men agreed that it is possible for a woman to be raped by her husband. Over a third of men (and nearly a quarter of women) agreed that a husband has the right to punish his wife for wrongdoing. These results again reflect the reality of patriarchal norms, with women beginning to understand and exercise their rights, but men believing that they have control over the lives of women.

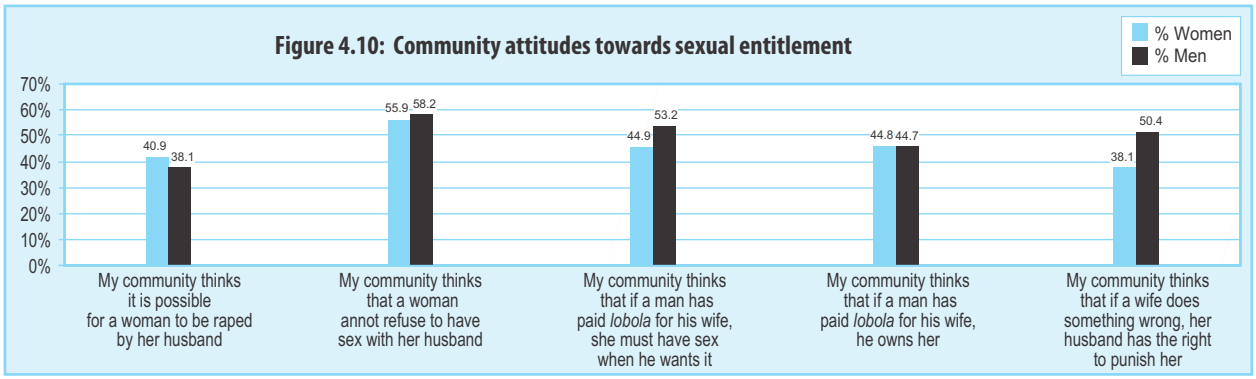


Figure 4.10 shows that women and men perceived that their communities had a high expectation of sexual entitlement to follow marriage. However a slightly greater proportion of women perceived their community to be more progressive than men.

Similar proportions of women and men agreed that their communities subscribed to wife ownership based on traditional marriage or payment of lobola. Forty five percent of women and men agreed that their communities prescribed that if a man paid Lobola for his wife then he owns her.

More men than women perceived that their communities had expectations of sexual entitlement to follow payment of lobola. Fifty nine percent of men and 56% of women thought that in their community a woman could not refuse to have sex with her husband. Fifty three percent of men and 45% of men agreed that their community expected a woman to have sex with her husband whenever he wants it.

Women and men perceived their communities as legitimising the use of violence to control women. Thirty eight percent of women and half of the men agreed that there was expectation in their community for men to punish their wives for doing wrong.

Societal factors

The political environment

The ecological model recognises the importance of societal factors in reinforcing or challenging gender stereotypes that create a conducive environment for GBV. As illustrated by the campaign against HIV and AIDS in Botswana, mentioned in Chapter one (Introduction), and in Chapter seven (Prevention) political leadership plays a key role in influencing public opinion, policy and social change.

An analysis of 188 available speeches by politicians from 2009-2011 obtained through the government, website, websites of political parties and the media show that politicians hardly refer to GBV in their speeches.

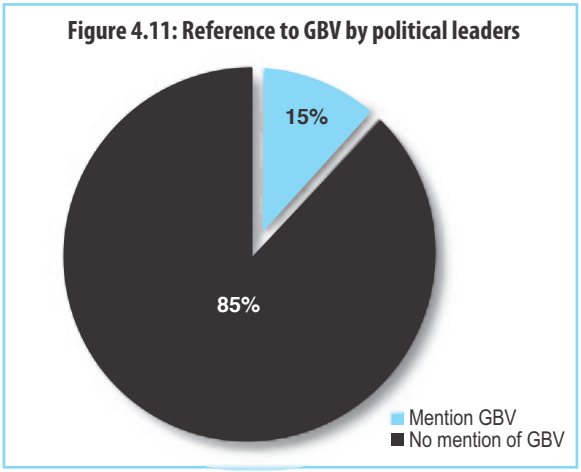


Figure 4.11 shows that of the 188 speeches analysed, 15% referred to GBV but only six percent had GBV as the main topic.

An example of a GBV speech is the speech by the assistant Minister of Local Government, Botlogile Tshireletso, at the start of the commemoration of the 2011 Sixteen Days of Activism to End Violence Against Women and Children. Speaking on behalf of the Parliamentary Women caucus, Tshireletso said that the theme, "From peace in the home to peace in the world: Let's End violence against women and children is well placed." She said that without peace in the home, there is no hope of building a healthy, productive and peaceful nation.[33]"

The study analysed speeches for reference to the different forms of GBV and reference to the extent of GBV in Botswana.

Figure 4.12: Forms of GBV referred to in speeches

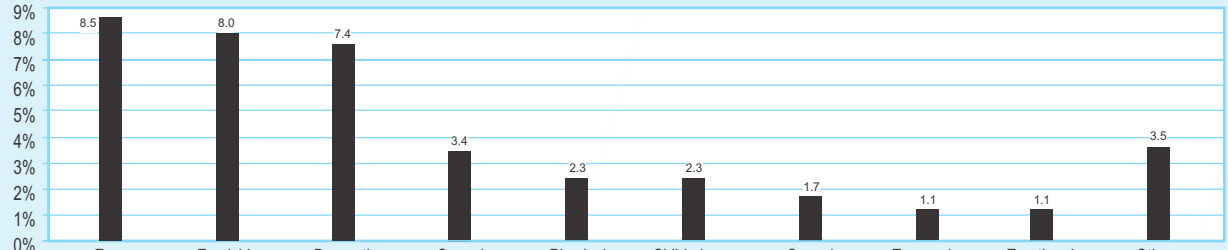


Figure 4.12 shows that although the prevalence study shows emotional violence to be the most widespread, politicians talk most about rape, femicide and domestic violence; these topics also dominate the media coverage. While they are serious concerns, they tend to obscure the "hidden" forms of violence, which get little state support.

The media

Political discourse and the media work hand in hand. What politicians say has a strong influence on what the media reports. Like politicians, the media can be part of the problem, or part of the solution, where fighting gender violence is concerned.

In October 2009, GL monitored 880 news items in Botswana as part of the Gender and Media Progress Study (GMPS) to examine amongst others the proportion of GBV coverage, GBV topics, who speaks, and who reports on GBV in Botswana.

Figure 4.13: Proportion of stories on GBV in Botswana

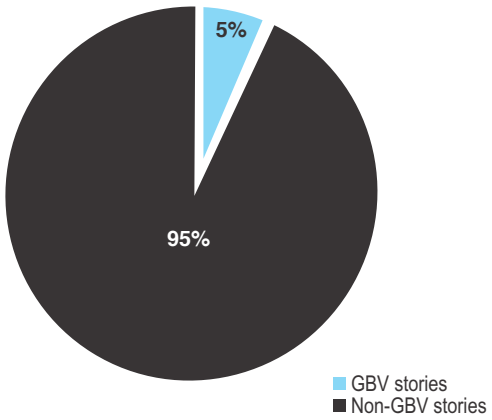


Figure 4.13 shows that GBV stories and stories that mention GBV accounted for only 5% of all stories monitored in Botswana.

[33] http://www.sundaystandard.info/print_article.php?NewsID=12618.

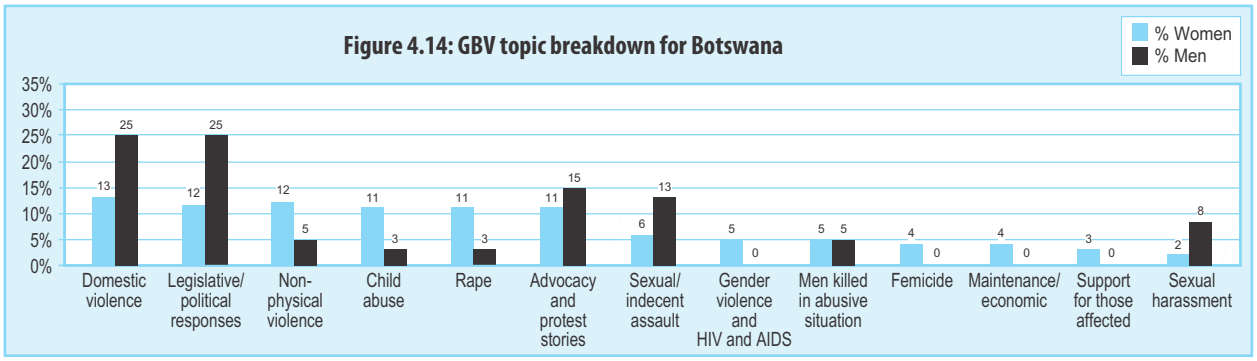


Figure 4.14 shows that domestic violence, and legislative and political issues received the most coverage in Botswana. None of the stories monitored concerned gender violence and HIV and AIDS, femicide, maintenance and economic topics, or support for those affected. Other topics that also received little coverage include rape, child abuse and non-physical violence. Women in the sample are experiencing emotional violence more than any other form of GBV.

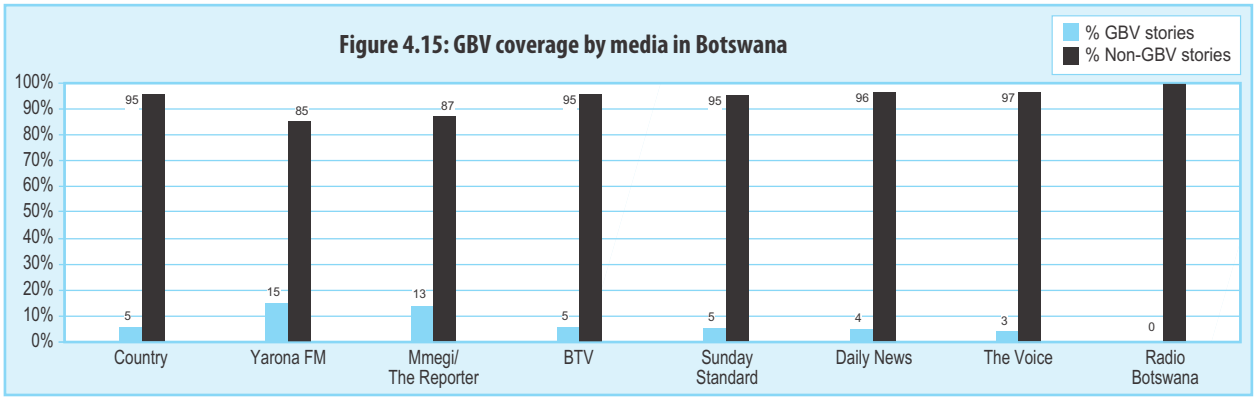


Figure 4.15 illustrates the proportion of stories on GBV per media in Botswana. Yarona FM had the highest proportion followed by Mmegi. Radio Botswana did not carry any stories on GBV during the monitoring period.

Who speaks on GBV?

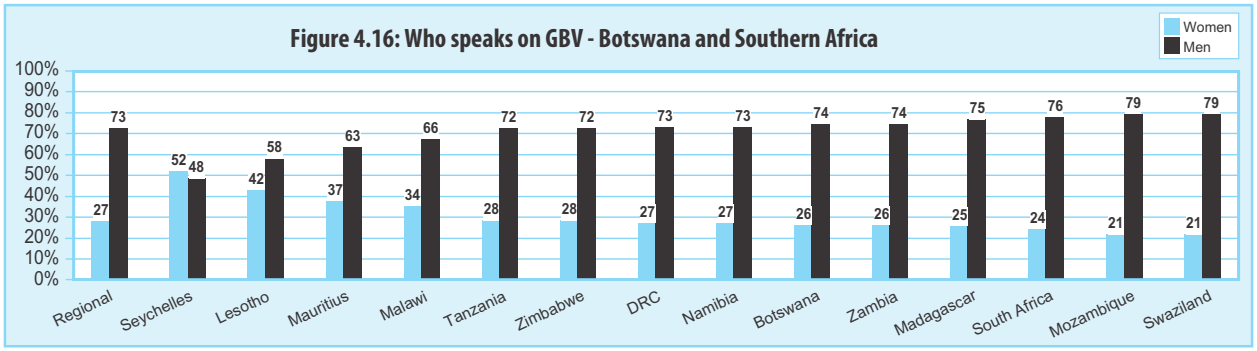


Figure 4.16 shows that women constitute 26% of sources on GBV in Botswana, compared to 27% in the region. These figures reflect the relative silence of women on a subject that clearly affects them far more than men. It is a telling indicator of the multiple layers of the conspiracy of silence that shrouds GBV.

Function of GBV sources

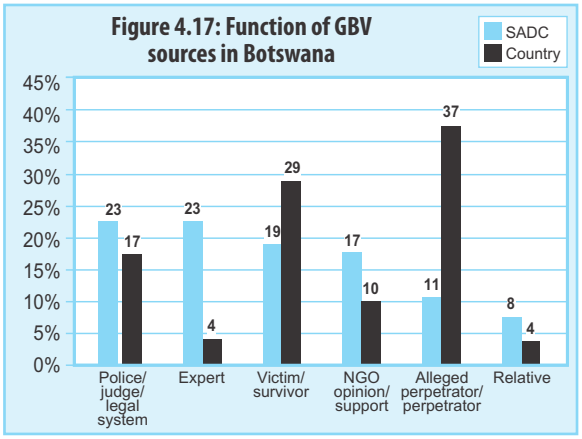


Figure 4.17 shows that in Botswana the alleged perpetrators are more than three times more likely to be heard in the media than the victims and survivors of GBV. The police and judicial systems and, ironically, perpetrators themselves, are the voices of authority in this instance.

Who reports on GBV?

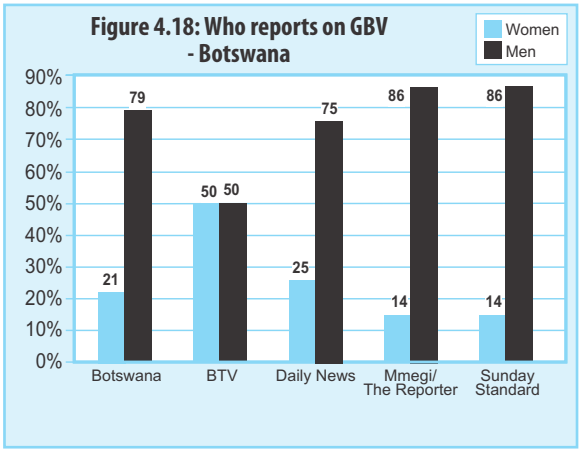


Figure 4.18 shows that men constitute the vast majority of media workers reporting on GBV. However, there are variations across media. BTV has reached the 50/50 benchmark, while in other media the representation of women is low with Mmegi/The Reporter and the Sunday Standard at not quite 15%

Figure 4.18 reveals that Botswana is one of the worst performers in this sector, with only one-fifth of women reporting on GBV. This figure is lower than the regional average of 35%.

How GBV is reported



As in other Southern African countries, the media in Botswana often reports GBV in senasational ways that trivialise the experiences of women. Coverage of femicide referred to as "passion killings", pose particular concerns. Use of the term passion suggests that these killings are justified. There needs to be a public dialogue on the term and its implications.

Conclusions

This chapter shows that GBV is rooted in the deeply patriarchal traditions and norms that are only beginning to be challenged by society. The voices of politicians and the media are still not loud enough in the campaigns against GBV. Women and men know about gender equality but information is still not resulting in attitude change. Age, education and employment status, alcohol and drug use, multiple sexual relationships and experience of violence in childhood exacerbate GBV.

CHAPTER 5
Effects



Gender violence has devastating effects, says Andrew Bosilong, Station Commander for Kweneng District Council. *Photo by Vincent Galatlhwe*

Key facts

- ✓ 18% of women who were physically abused sustained injuries and over half of the injured women had to stay in bed for an average number of nine days.
- ✓ A quarter of all the women interviewed suffered from STIs at some point in their lifetime.
- ✓ Women who experienced IPV or rape were more likely to have STIs.
- ✓ A tenth of women and above a fifth of men interviewed in this study had never tested for HIV.
- ✓ 26% of women who experienced physical IPV in their lifetime were HIV positive.
- ✓ 20% of women who experienced sexual IPV in their lifetime were HIV positive.
- ✓ 15% of women who were raped in their lifetime were HIV positive.
- ✓ 8.7% of women who experienced IPV in their lifetime attempted suicide.
- ✓ 15% of women who were raped in their lifetime attempted suicide.
- ✓ 11.6% of women who experienced IPV in the 12 months to the survey attempted suicide.
- ✓ 30.8% of women who were raped in in the 12 months to the survey attempted suicide.
- ✓ 30.4% of men agreed that in any rape case the victim has to be questioned for promiscuity while 18.2% of women agreed to this.
- ✓ 18.3% of men agreed that if a woman is raped, she is to be blamed for putting herself in that situation, whilst 7.3% of women agreed to this.
- ✓ Politicians do refer to the effects of GBV, but not on the economy or the individual. They are mostly concerned about the links between GBV and HIV.



"I (Joyce[34]) tried to commit murder and suicide after I found out my partner was having an affair. I thought he was the one who infected me with the HIV and AIDS.

"Itried to commit murder and suicide after I found out my partner was having an affair. I thought he was the one who infected me with the HIV and AIDS.

It started one evening when I got home and found him with another woman. I got angry and thought it was not worth living with him as a trusted partner. I started losing my mind. He was always cheating.

It was just too much for me. He would hurt me, apologise and I would forgive him.

He knew my strong and weak points. He used to tell me painful things and I would accept them knowing that I love him. This love turned into a nightmare. He cheated on me three times but I just accepted he is a man. He decided to end our relationship, I agreed, but I was devastated. I agreed to do that because he forced me to. Later he came back to me, he apologised for everything and I fell for it because I've always wanted to hear that.

When I found him with the lady in our home, I went straight to him and told him that I was going to kill him. He thought I was losing my mind. Instead I decided to take the paraffin and matches and burn the house. He called the police thinking that I am losing my mind or crazy, some people were saying I was on drugs.

The police officer later referred me to a counselling session. Although I was not so willing, he said I needed counselling. That was how I met them with the Pastor (Chaplin office Police). I attended the every session, I never missed a single one. It was very interesting, I learnt and benefited a lot from it. I want to thank everybody who stood by me during this period. I am grateful to the Phikwe Police, local councillors and pastors for not giving up on me because without their support I do not know where I would be by now. I appreciate it a lot.

I have recovered from all that pain and shock. As I am writing I am waiting for the results from my CD4 count. I am fine health wise and I have learnt to live without him."

Joyce* contracted HIV as a result of her husband's promiscuity. Discovering her husband with another woman in her home was a turning point in her life. Joyce* has received help but her experience almost led her to murder.

This chapter reports on the effects of GBV on women participating in this study. The prevalence and attitude survey asked women questions on a range of indicators about their health, including contraceptive use, condom use, HIV testing and results, sexually transmitted infections, and aspects of their mental health.

[34] Not her real name.

Physical injuries

The effects of physical abuse include death; permanent disability such as blindness, deafness, seizures, loss of mobility; hospitalisation for broken bones, concussion, head and spinal injuries; gynaecological problems including losing an unborn baby, or birth defects; infertility; treatment for broken teeth, cuts, headaches; and bruises, pain, trauma. Women who participated in the survey were asked about the injuries they sustained as a result of physical abuse.

Table 5.1: Prevalence, frequency and severity of injuries by physically abused women

Criteria	
% of physically abused women who suffered injuries	18.1
Average number of times injured	3
% of physically injured women who spend days in bed because of injuries	53.8
Average number of days in bed	9
% of physically injured women who took days off work because of injury	33.3
Average number of days off work	4

Table 5.1 shows that 18% of physically abused women sustained injuries an average of three times. Over half (54%) of the injured women had to stay in bed for an average number of nine days. A third of the women (33%) lost an average of fourdays of work because of injuries sustained.

Sexual and reproductive health

The effects of GBV may include pregnancy, miscarriage, inability to negotiate condom use during sex, sexually transmitted infections including HIV, and pregnancy-related problems.

Sexually transmitted infections

The survey asked women about their experiences of sexually transmitted infections in a lifetime. Questions included if they had had an ulcer on the vagina; whether they had had a discoloured, smelly, itchy or uncomfortable discharge from the vagina and whether they had an STI.

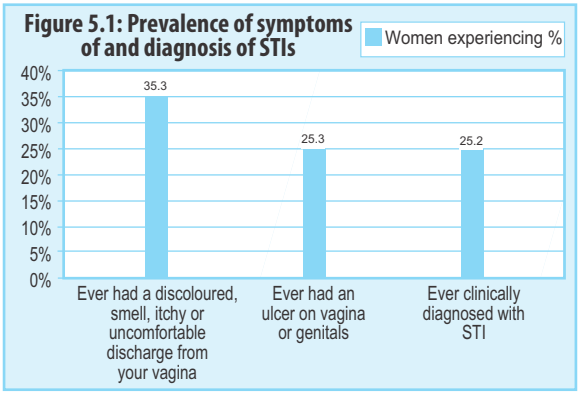


Figure 5.1 shows that a quarter of the women interviewed had an STI at some point in their lifetime. Over a third (35%) had experienced the symptoms of a discoloured, smelly and itchy vaginal discharge while a quarter had a vaginal ulcer at some point in their lifetime.

Table 5.2: STI's and experience of IPV by women

	Never experienced IPV	Ever experienced IPV	Never experienced physical IPV	Ever experienced physical IPV	Never experienced sexual IPV	Ever experienced sexual IPV	Never raped	Ever raped
Ever diagnosed with STI %	14.44	30.88	19.7	34.18	23.21	34.12	22.5	43.5

Table 5.2 shows a high level of correlation between STI's, IPV and rape. Nearly one third of women who experienced IPV and 44% of those raped also had STI's.

Galebolelwe* spoke of how she contracted an STI because of her partner's risky sexual behaviour. Her partner was not willing to be treated and so she had repeated infections. She said: "I remember one day I was infected with a sexually transmitted infection (STI). I went to the hospital where I was given a partner track slip to give him. He was angry with me and he said he was not a hospital person. He took the track slip, tore it into small pieces and threw them at my face. He even vowed that he will continue with unprotected sex on me no matter what health practitioners say. According to their instructions, I was supposed to recover fully before I could indulge in sexual intercourse. I had told him that, but he ignored my advice and that of health experts. I was then a repeated STI patient at the clinic which humbled me and made me socially insecure."

HIV and AIDS

Previous research in different settings has shown a positive association between GBV and HIV. This study did not test for HIV but asked women whether they had tested for HIV and the result they obtained.

Table 5.3: HIV testing and results

When did you last have an HIV test	% Women	% Men
Never tested	10.2	21.6
Last 12months	67.7	5.9
2-5yrs ago	16.6	13.8
More than 5 years ago	5.6	58.7
HIV Status		
Negative	81.1	86.5
Positive	18.9	13.5

Table 5.3 shows that a tenth of women and above a fifth of men interviewed in this study had never tested for HIV. The majority of men (59%) only tested for HIV more than five years ago. These findings indicate the need for accelerated efforts aimed to encourage men to test regularly for HIV and get to know their status. Nineteen percent of women and 14% of men that had ever tested for HIV reported being HIV positive. These figures correlate with the national HIV prevalence rate of 17% (UNAIDS, 2010).

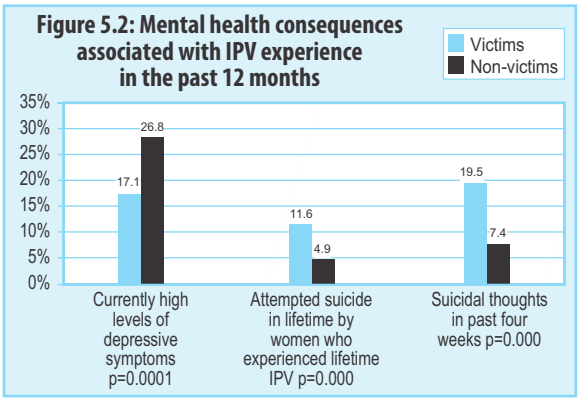
Table 5.4: Association between GBV and HIV

	Any sexual IPV		Any physical IPV		Any rape	
	% Non-survivors	% Survivors	% Non-survivors	% Survivors	% Non-survivors	% Survivors
HIV positive	18.3	20.3	14.5	26.1	19.4	15
P value	0.7		0.001		0.05	

Table 5.4 shows a significant association between experience of physical IPV and sexual assault by women and their HIV positive status. Over a quarter (26%) of women who experienced physical IPV in their lifetime reported being HIV positive. Twenty percent of women who experienced sexual IPV and 15% of women raped also reported being HIV positive. The current prevalence of HIV in Botswana is estimated at 17%. The prevalence of HIV amongst women who have experienced some form of IPV is higher. These findings show that women who experience GBV are at higher risk of contract HIV.

Table 5.5: Mental health consequences associated with GBV experience in a lifetime				
	IPV experience		Rape experience	
	% Non-survivors	% Survivors	% Non-survivors	% Survivors
Attempted suicide in lifetime	3.7	8.7	6.0	15.1
	p=0.02		p=0.0005	

Table 5.5 shows a correlation between lifetime experiences of IPV and rape with attempts to end one's life ($p<0.05$).Nine percent of women who experienced IPV in their lifetime attempted suicide while four percent of women that did not experience IPV also attempted suicide. Fifteen percent of rape survivors attempted suicide.





Matshelo, trainee conducting an interview during the GBV indicators training at kagisong centre in Botswana. *Photo by Kabelo Tsiang (WAD)*

Figure 5.2 shows a correlation between experience of IPV in the 12 months to the survey with suicidal thoughts and attempted suicide. Twelve percent of women who experienced IPV had attempted suicide while 20% had had suicidal thoughts in the four weeks prior to the survey.

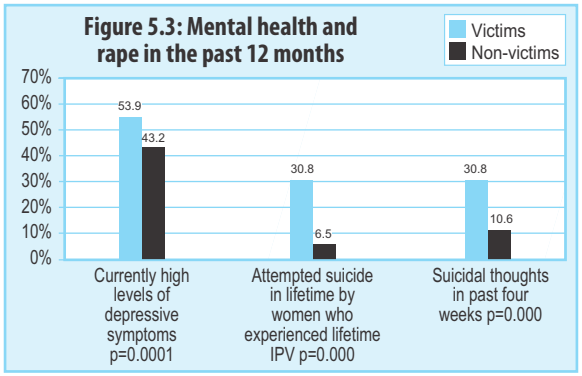


Figure 5.3 shows that in the 12 months before the survey those who experienced rape also suffered from depression, suicidal thoughts and attempted suicide. Over half (54%) of women raped had depressive symptoms. Thirty one percent of rape survivors had attempted suicide and a similar proportion had suicidal thoughts in the four weeks before the survey.

Violet* spoke of how she and her children were stressed first because her partner did not provide for the family and secondly because of his promiscuity. Violet said: "Whenever I saw him passing my heart would be filled with pain. I found out that he was going out with different girls from their church. He left his children for children who were not his. At times when I called him for his children the girl who will be with him would answer and insult me. I then assigned

my younger sister to contact him when the children needed something; some of the young girls he was dating were my relatives. I was devastated and lost weight. At that time I was breastfeeding, my older daughter was also young. I did not have money and my mother was not in a position to assist us financially. I relied on him because my business was not doing well. I had to stop breastfeeding because I lost weight. I was scared my stress will interfere with my health."

Stigma and secondary victimisation

Communities often blame survivors of rape for being promiscuous and seducing the perpetrators. Women and men participating in the survey responded to questions about their personal views of rape survivors as well s their perceptions of community views.

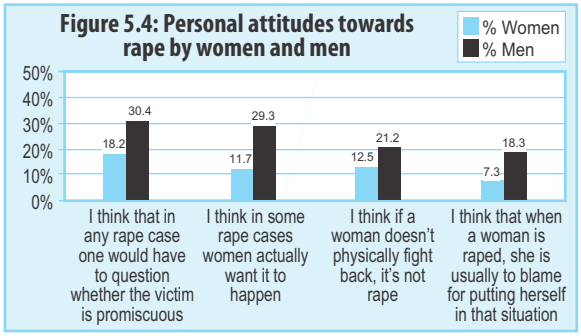


Figure 5.4 shows that thirty percent of men , and 18% of women agreed that in any rape case the victim has to be questioned for promiscuity. Twenty- nine percent of men and 12% of women agreed that in some rape cases women "wanted it to happen."

Twenty one percent of women agreed that if a woman did not fight back then it could not be rape. Twelve percent of women agreed to this. Eighteen percent of men agreed that if a woman is raped, she is to be blamed for putting herself in that situation. Only seven percent of women agreed that in any rape situation the woman should be blamed for putting herself in that situation.

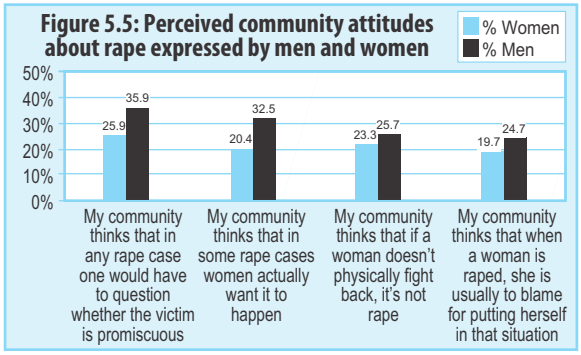


Figure 5.5 shows that women and men perceived their communities as not being supportive of rape survivors. More men than women perceived this. Twenty six percent of women agreed that their community associated experience of rape with promiscuity while 36% of men agreed to this. Twenty three percent of women and 26% men agreed that in their community when a woman did not physically fight back, then it was not rape. A fifth of the women (20%) and a quarter of the men (25%) of men perceived their communities blamed the rape survivors.

Costs of leaving

Violet[35] also spoke of her fears about leaving the abusive relationship. Her main worry was how she would support her two daughters by herself. She said:

"My daughters loved him dearly especially Ursular the elder one. I was not working, how would I face life alone? All these years I was with him sharing things together, I was afraid, I did not see myself he was supposed to provide. He was a hard worker. I supported him all these years and he was appreciative. When he started sleeping out and refusing to sleep with me I uttered insults and reminded him

[35] Not her real name.

where he was coming from. He insulting me in return. Pastors and some friends tried to help us but it was not working. After finding out that he was not interested I decided to let it go but it was not easy."

Alice[36], now a divorcee spoke of what she lost when she parted ways with her abusive husband.

"I am writing about the way my husband abused me. We got married in 1995 at the District Commissioner's office in Kasane. I was working in Maun while my husband was working in Gantsi District. In 1998 I was transferred to join my husband in the Gantsi District. That was when our relationship became sour.

My husband was having an extra-marital affair with a policewoman who was my colleague. Their relationship was so serious that it wrecked our marriage and she would even brag about it at work. My husband later applied for divorce without consulting me. I was only served with divorce papers.

We got divorced in October 2006 at the Lobatse High Court. Now he is not maintaining the children as he was meant to. Sometimes he stays for about five months without giving me anything for the children. When I ask him, he tells me that if I am failing to take care of the children then I should give him custody of the children. The High Court had ruled that he should maintain the children with P300 per month.

When I talk to him about the welfare of children he tells me that I can go and report at Magistrate Court. He also does not want the children to stay with me and beats them up. I was always reporting to the police.

I was given a pool house when we separated. He refused to give me some of the furniture to use. I used to sleep on the floor, but eventually bought myself furniture. After the divorce I was also given a share of our property since by then I was also transferred to my home village, Kasane.

This man used to abuse me sexually, while he was staying at his girlfriend's place. He would force me to have unprotected sex with him."

How politicians view the effects of GBV

The analysis of speeches showed that in the speeches that referred to GBV, 88% referred to the effects of GBV. The highest proportion of these referred to contracting HIV. Politicians made virtually no reference to the other effects of GBV such as poor mental health and costs to the economy.



Roos van Dorp at the Gender Links publications stall in Nata, Botswana. *Photo by GL Botswana*

[36] Not her real name.

Conclusion

The study found increased risk of physical injuries, poor mental health effects and contracting STIs or HIV among women who experienced GBV. For both women and men it affirmed a stigma associated with being a rape survivor. The political content analysis shows that politicians in Botswana are mostly concerned with the effects of GBV on increasing the risk of HIV infection.

CHAPTER 6
Response and support



Women's shelters in Botswana are few and far between. *Photo by Colleen Lowe Morna*

Key facts

- ✓ 80.1% of women and 77.8% of men were aware of laws that protect women and children against abuse.
- ✓ 46.2% of women and 42.5% of men said they had heard about the Domestic Violence Act.
- ✓ 19.6% of women and 24.4% of men heard about the Penal code sections 141-143
- ✓ 33.9% of women and 31.4% of men were aware of protection orders
- ✓ Radio is the main source of information on the Domestic Violence Act and the Penal code sections 141-143
- ✓ The prevalence of GBV reported in the survey is 24 times higher than that reported to the police. In the survey, only about one in nine women raped said they reported this to the police. This suggests that women still have little faith in the criminal justice system.
- ✓ Of the cases reported to the police in 2011, 9.5% got withdrawn.
- ✓ Of the 5185 cases of sexual, physical, emotional and economic violence before the courts 1883 cases (36.3%) resulted in prosecution. Some 30% resulted in conviction .
- ✓ With a prevalence rate of nearly 30% over the last year (according the survey) Botswana had 204 938 women who experienced violence. Of these, only 1596, or 0.6% got relief through the courts. This means that men who perpetrate violence literally get away with it.
- ✓ There are only two places of safety for women: Kagisano Women's Shelter in Gaborone provided counselling services to 396 clients in 2010, and Molepolole DIC provided counselling services to 147 survivors in 2011. Lifeline Botswana provided counselling to 144 GBV clients. This suggests a total capacity of about 687 per annum for counselling services.
- ✓ Although leaders acknowledge that support for survivors of violence is a state responsibility, there is still a wide gap between the services available and the need.



"I (Candice[37]) am a 23 year old young woman who has experienced emotional, verbal and sexual abuse in the relationship I have had since 2005. I had an organised and ordered life before I fell in love with a young man of 25 years old. I made him tell me his intentions for the relationship.

I learnt that the young man was a mechanic and a tattoo brander. I was attracted to his economic independence. My boyfriend also seemed to enjoy the fact that I agreed to be in a relationship with him. Peer-pressure and my poor background prompted this union. He promised that he would support me unconditionally. He promised me heaven and everything good. This assured me I had found a brilliant and focused permanent partner.

He was 25 years old when I was only 18. He had the habit of drinking and after getting drunk he would force me into having unprotected sex with him despite my advice on unprotected sex. He would sometimes call me degrading names when I tried to caution him on his behaviour. I remember one day when he wanted to have sex with me and when I refused he said: '...you poverty founded moron, don't you know that I do as I please with you?. 'I had a dysfunctional relationship, full of distress and bitterness. He seemed to enjoy my lamentations. By 2006 he had started drinking extra ordinarily. He demanded to make me a tattoo of his name, which meant we would never separate. Life did not have meaning to me, being verbally and sexually abused and now being inscribed an enemy's name, it was hell.

One day I found I had a sexually transmitted infection (STI). The hospital gave me a partner track slip to give him. He responded angrily refusing to go to hospital. He took the track slip, tore it into small pieces and threw them at my face. He vowed to continue unprotected sex no matter what health practitioners said. I became a repeated STI patient at the clinic; making me socially insecure.

I devised a plan to end this relationship amicably to no avail. In April 2006, I went to see a social worker at Botswana National Youth Council (BNYC). I poured all my sorrows out to him in a counselling session. It took me only that day and I felt psychologically, spiritually and mentally relieved. He also gave me a number of alternatives and referrals to choose from. I told my boyfriend it was all over. He threatened to beat me and to follow me everywhere. I reported the matter to the police, who reprimanded him and I was saved from the abuse. Since then I have decided to make wise choices about my life.

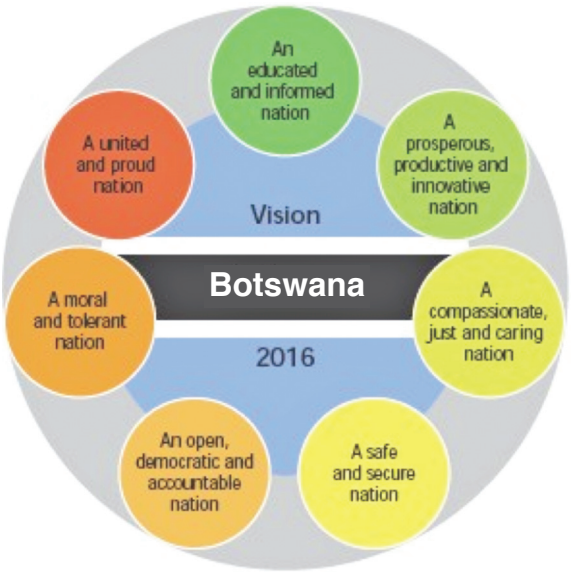
I feel NGOs should be supported to execute their duties aimed at ending gender violence by instilling human norms and positive living holistically. I would like to advise young people to associate with NGOs in their localities like I did with BNYC to gain knowledge that would enable them to shun GBV and other forms of abuse."

[37] Not her real name.

Candice's story of abuse illustrates the need for response and support structures that provide services for GBV survivors. Candice sought medical help and went to the BNYC for counselling. Many women return to abusive relationships because they have nowhere to go.

Effective response and support services give survivors a viable and safe alternative. However many of these services are being provided by civil society organisations that lack secure and adequate finances. This chapter explores the response and support to survivors of GBV from the macro policy level to services available on the ground.

Policy formulation



In 1997, the Government of Botswana adopted *Vision 2016,* which reviews the first thirty years of independence and charts the course to this landmark fiftieth anniversary of independence. *Vision 2016* is Botswana's strategy to propel its socio-economic and political development into a competitive, winning and prosperous nation.

It is envisaged that by this year, a number of challenges in Botswana's long-term goals for development will have been met. This long-term vision has seven strategic pillars or goals including by the year 2016, Botswana will be a moral and tolerant nation with citizens who are law abiding, strong in religious and spiritual values, and who possess high ethical standards. The vision defines a tolerant nation as one blind to gender, age, religion or creed, colour, national or ethnic origin, geographical location, language or political opinions. It envisaged that by 2016 human rights will reign supreme, with no abuse of children, the disabled and women.

Pillar four within the Vision is the aspiration of "a Safe and Secure Nation by 2016". According to the Vision document:

> "By the year 2016, violation of the physical well-being and human rights of individuals will have ended, along with the abuse of spouses and children. The public will have sufficient confidence in law enforcement agencies and in public protective services to report crimes. Law enforcement procedures will be strong. The training of national and local police forces will be integrated and developed".

To achieve this goal, the country must establish effective programmes that will assist victims within the criminal justice system. One strategy for building a safe and secure nation identified in the Vision is that:

> "We must equip and train the police in an integrated way at national and local level to deal with the rising crime rate. There should be stiff penalties for crime of all kinds, and a major public campaign to eradicate violence and corruption.

Legislative framework

An effective legal framework is a precondition for ending violence against women. It indicates a government's commitment to ensure an approach to solving the problem. Indicators for measuring legislative GBV response include measures to ensure rights are recognised and protected from international, statutory and traditional laws and

policies. Botswana has made considerable progress in acceding to international policies and laws that aim at the eradication of discrimination against women. However these are to be found scattered in many different laws.

In Botswana, the Constitution guarantees every person whose human rights are violated the right to recourse. Laws that relate to GBV include the Domestic Violence Act, the Penal Code, the Criminal Procedure and Evidence Act, the Employment Act and the Deeds Registry Act.

Domestic Violence Act No. 10 of 2008

The Government of Botswana passed the Domestic Violence Act; No. 10 of 2008 in order to protect women who are in a domestic relationship. A domestic relationship is defined as one between married persons, cohabiting partners, children, family members, co-tenants, partners who were engaged, dating or in a romantic relationship. Violence is defined as "any controlling or abusive behaviour that harms the health or safety of the applicant" . The types of violence listed include physical, sexual, economic, emotional, intimidation, harassment, stalking and damage to property.

> "A domestic relationship is defined as one between married persons, cohabiting partners, children, family members, co-tenants, partners who were engaged, dating or in a romantic relationship."

This Act seeks to provide survivors of domestic violence with protection. According to the Act:

- Courts including the customary courts have the jurisdiction to pass orders available to applicants such as restraining order, occupation or tenancy orders, interim orders which seek to immediately protect applicants (victims).
- Courts may also authorise the issue of warrants of arrest for the offender
- Courts can charge a fine not exceeding P5000 or imprisonment for a term not exceeding two years for contravening an order.
- The registrar of the court should maintain a register of all applications filed under the Act and all orders issued.

When an interim order is passed a member of the Botswana Police Service should:

- Prohibit the offender from committing an act of domestic violence.
- Prohibit the offender from entering specific parts of the residence.
- Prohibit the offender from communicating with or contacting the survivor.
- Remove immediately the survivor from the residence.
- Accompany the survivor to the residence to supervise the removal of personal belongings.

There are several gaps in the Domestic Violence Act such as the exclusion of marital rape. Marital rape was found to be a fairly common experience for women in Botswana, married women have no recourse to the law because marital rape is not recognised as an offense punishable by law. This is fuelled by the traditional perception that by paying bride wealth, a husband has purchased unlimited conjugal relations with his wife and has exclusive control over her reproductive functions.

The Penal Code (Amendment) Act of 1998

The 1998 amendment of the Sexual Offences sections 141-143 in the Penal Code was an effort by the State to respond to the need to protect women against violence. The amendment introduced stiffer penalties against rape offenders. According to the Act:

- A person charged with rape is denied bail and on conviction shall be sentenced to a minimum term of ten years imprisonment (the denial of bail was however declared unconstitutional by the High Court and is therefore no longer applicable).
- Where the rape is accompanied by violence resulting in injury to the victim, the minimum sentence is fifteen years.

- A person convicted of rape is required to undergo an HIV and AIDS test before sentence is passed, and if he/she tests positive shall be sentenced to a minimum term of fifteen years.
- Where it is proved that on a balance of probabilities such person was aware of being HIV positive, he/she shall be liable for a minimum term of twenty years with corporal punishment. The problem with implementing this requirement is finding proof that the convict may have known his/her status or not.

Criminal Procedure and Evidence Act

The amendment of the Criminal Procedure and Evidence Act introduced in-camera hearings in courts for sexual offences. This created a victim friendly system that protects rather than victimises.

The amendment states that trials related to rape, attempted rape, indecent assault on any women or girls, defilement of girls under 16 years old and indecent assault on boys under 14 years old, are to be held within closed doors. In the case of trials held within closed doors, only members and officers of the court, parties to the case, their legal representatives and witnesses and any other persons the court specially authorizes shall be present at the sitting.

Newspapers are also prohibited from publishing pictures of victims or complainants and revealing information which may lead to identification of the victim or complainant thereby effectively protecting victim's integrity and identity.

Abolition of Marital Power Act 34 of 2008

The abolition of Marital Power Act 34 of 2008 promotes gender equality by providing for equal powers in community of property for spouses. The Act aims to :

- provide for the abolition of the husband's marital power over his wife;
- amend the matrimonial property law of marriage to bring about spousal equality;
- provide for the domicile of married women to give them full capacity; and
- provide for equality between spouses with respect to the domicile and guardianship of minor children.

Under the Act, people married in community of property have equal capacity to dispose assets of the joint estate, administer the estate and contract debts for which the joint estate is liable. A spouse married in community of property may also perform any legal act regarding the joint estate without the other partner's consent.

However, consent is required when a spouse seeks to cede any shares, insurance policies or any investment by or on behalf of the other spouse, pledge any livestock, jewellery or other assets forming part of the joint estate. Other acts which require consent of a spouse include receiving money due to the other spouse or joint estate through earnings, pension, inheritance, bursary, income from the separate property of the other spouse or dividends or proceeds of shares in the name of the other spouse.

Public Service Act 2010

The Public Service Act prohibits sexual harassment in both the public sectors. Sexual harassment committed by a public officer is considered misconduct and punishable by termination, with or without forfeiture of all retirement benefits, suspension with loss of pay and benefits for up to three months, reduction in rank or pay, deferment or stoppage of a pay raise, or a reprimand.

Deeds Registry (Amendment) Act of 1996

The Deeds Registry Act was also amended to enable women married in community of property to register immovable assets in their names and to empower them to give consent when joint property is disposed of.

Awareness of legislation

Laws are only as effective as legal literacy and access to justice. The survey asked if respondent know of laws in Botswana that protect women and children against abuse, the Domestic Violence Act, Protection Orders and of sections 141-143 of the Penal Code.

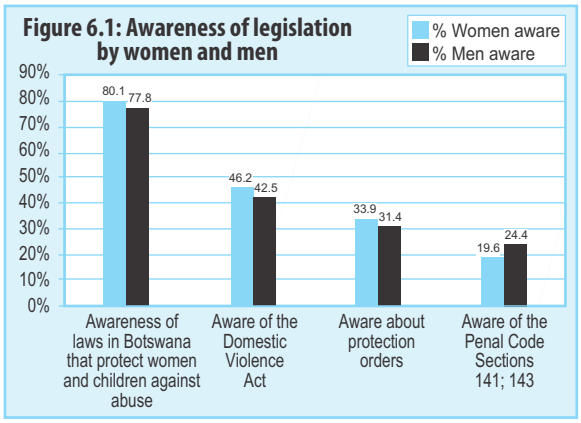


Figure 6.1 shows that 80% women and 78% of men know of laws that protect women and children against abuse. A smaller proportion (46% of women and 42% of men) said they had heard about the Domestic Violence Act. A third of women and 31% of men respectively reported being aware of protection orders. More men (24%) than women (19%) knew about section 141-143 of the Penal Code.

These findings show that while there is a general awareness about laws there is a lack of specific knowledge of the Domestic Violence Act and Penal Code. There is an urgent need to raise awareness about these laws for women to understand and exercise their rights. The Domestic Violence Act is more known to women and men compared to the 1998 Amendment of the Penal Code because of deliberate and concerted efforts to raise awareness after its passing. Government and civil society organisations need to continue to raise awareness of laws to improve the reporting of cases and access to justice by women and men. It appears that it is either not being used or that no records are kept of applications under it. The Minister of Justice was recently unable to provide any stats in this regard. Section 20 requires the Registrar of the Court is expected to keep a register of applications under it.

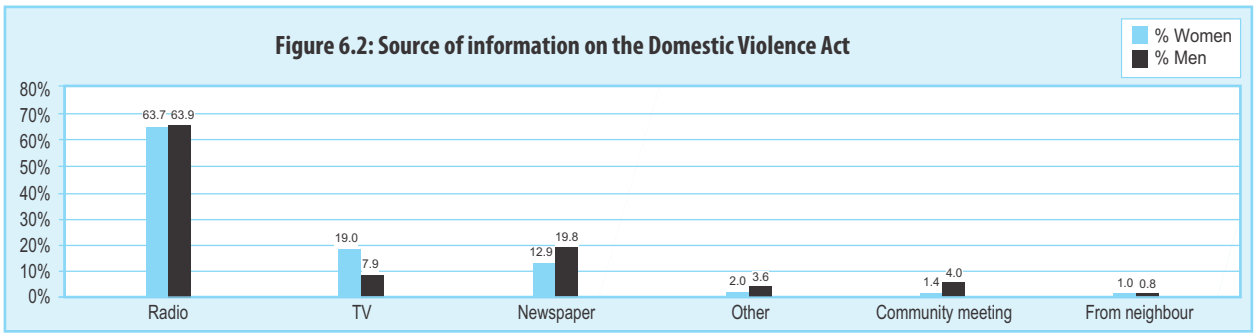


Figure 6.2 shows that 64% women and men learned about the Domestic Violence Act via the radio, followed by TV and newspapers. This shows that radio has the widest reach of all media in Botswana.

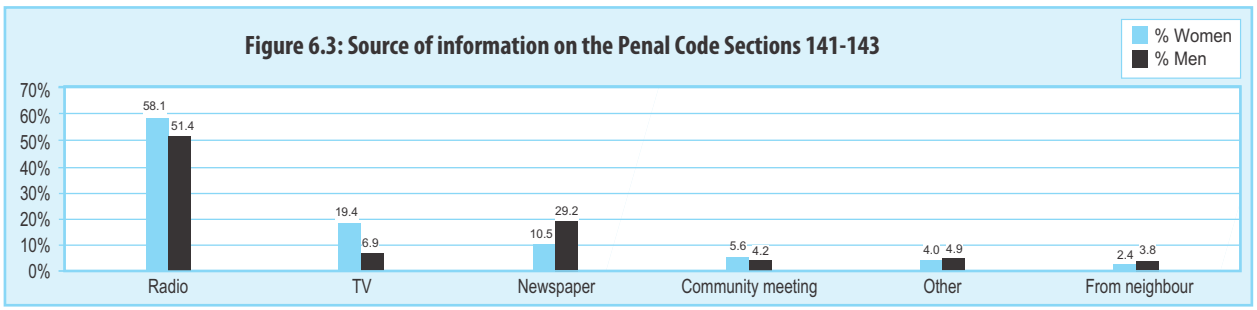


Figure 6.3 shows a similar trend on the source of information on the Penal Code section 141-143: radio followed by television and newspapers. More women than men had heard about the sections on radio and television, while more men than women obtained information from newspapers. This is consistent with other audience research surveys that show that men generally access the print media more than women do.

Public services

This section presents results from administrative statistics on GBV. The administrative component of the study aimed to:

- Conduct an inquiry on the type of data available from institutions dealing with GBV and how this data can be accessed.
- Compile the actual GBV data from identified institutions.

GL and WAD obtained data from both governmental and non-governmental organisations. Government departments evaluated include the:

- Botswana Police Service - Public Relations and Operations Unit
- Directorate of Public Prosecutions in the Attorney Generals Chambers
- Department of Social Service in the Ministry of Local Government
- Tribal Administration in the Ministry of Local Government
- Health Research Unit in the Ministry of Health
- Demographic Statistics Unit in the Statistics Botswana
- The District Commissioners' Office
- The Magistrate's Courts

Botswana Police Service (BPS)

The Police Stations submit crime reports regularly to the Operations Department at the head quarters in Gaborone who analyse and classify them. The Operations department forwards statistics to the Public Relations Unit.

The aggregated statistics feature in the Police Commissioner's Annual report. This disaggregates data by gender and age. The annual reports also include information on the outcome of the cases. The Criminal Records Information Bureau keeps records of previous convictions.

The way that BPS collects data on GBV has progressed significantly in the last few years. Since 2009, police have started to keep more detailed registers of GBV cases. The gender focal points in Police Stations compile their station statistics and submit them to the Botswana Police College on a monthly basis. A co-ordinator at the Botswana Police College compiles all the GBV cases from police stations into one report.

This helps to disaggregate the different kinds of GBV. The comparable categories in this study make it possible to compare the prevalence rate as reported to the police, with that in the population survey. This assists in understanding the degree of underreporting that, in turn, points to the need for policy measures to ensure the criminal justice system is more responsive to GBV.



Police Presence at Kgatleng community march. *Photo by GL Botswana*

Table 6.1: Comparative analysis of BPS and SAPS data classification system			
General GBV data concern	**Botswana Police Service (BPS)**	**South Africa Police Services (SAPS)**	**Comments**
General GBV data concern Police statistics often do not capture the many forms of GBV, especially the less obvious emotional and psychological forms.	BPS data is categorised into physical, sexual, economic and emotional GBV. BPS has an added category - spiritual violence.	SAPS recently introduced a category for domestic violence. But this needs to be accompanied by information on relationship to make sense of the data.	SAPS promised to add relationship to the check-box following the Gauteng GBV indicator study. BPS categorisation into physical, sexual, economic and emotional categories is a progressive move.
Most police services have no specific category for femicide (the murder of a woman by her intimate partner). Gender disaggregated data on murder does not give conclusive information on femicide; researchers have to do docket analysis to determine if the murder of women is indeed femicide.	BPS includes murder as a GBV crime. Because BPS also has relationship categories it is possible to ascertain if an intimate partner murdered a woman; therefore whether this constitutes femicide.	SAPS has No category for femicide, although SAPS promised to introduce this category after the launching of the Gauteng GBV indicators study.	SAPS has gender disaggregated data on murders and agrees it would be possible to include femicide as a separate GBV category.
Police data often excludes marital rape.	No category for marital rape.	SAPs have a category for rape of wife by own husband and attempted rape by own husband .This helps to ascertain marital rape from the domestic violence data.	BPS does not register rape in marriage because marital rape is not recognised as a crime.
Police data often does not disaggregate intimate from non-intimate partner rape.	BPS registers rape by intimate partners outside the marriage context for example an ex-partner, a dating partner and cohabiting partner. In this way it is possible to ascertain rape by non-partners as opposed to partners.	No category for sexual violence by partners outside the marriage.	Although SAPS has a rape category under domestic violence, this cannot be disaggregated into partner and non-partner rape because of the absence of relationship information between victim and perpetrator.

Source: Gender Links, BPS, SAPS.

Table 6.1 shows that the BPS is currently collecting data for the different GBV forms in more comprehensive ways than the South African Police(SAPS). Unlike SAPS, BPS collects data on femicide, intimate partner, economic and emotional violence. The disaggregation of police data allows for a distinction to be made between people in the domestic set up and intimate partner violence. Collection of GBV data by BPS is an international good practice. Data in this form is useful in making multi-country comparisons on the extent of routinely reported GBV. The only gap in police data collection in Botswana is marital rape (not yet recognised in legislation).

Table 6.2: Statistics on GBV obtained from the BPS Public Relations Unit									
Offence	2003	2004	2005	2006	2007	2008	2009	2010	2011 January-June
Rape	1504	1517	1540	1534	1504	1875	1754	1865	893
Indecent assault on females	92	107	91	115	92	138	130	212	85
Femicide (Passion killings)	46	52	73	59	46	80	87	102	45

Table 6.2 shows a general increase of reported cases of rape, indecent assault and femicide over the years. The number of reported rape cases has increased by 24% from 2003 to 2010. During the same timeframe, the number of recorded femicides, or so called "passion killings" showed a 122% increase. In the first six months of 2011, 45 women lost their lives at the hands of an intimate (ex-) partner.

The 2011 BPS annual report records a total of 8165 GBV cases involving female victims above the age of 18; compared to 8177 male perpetrators.

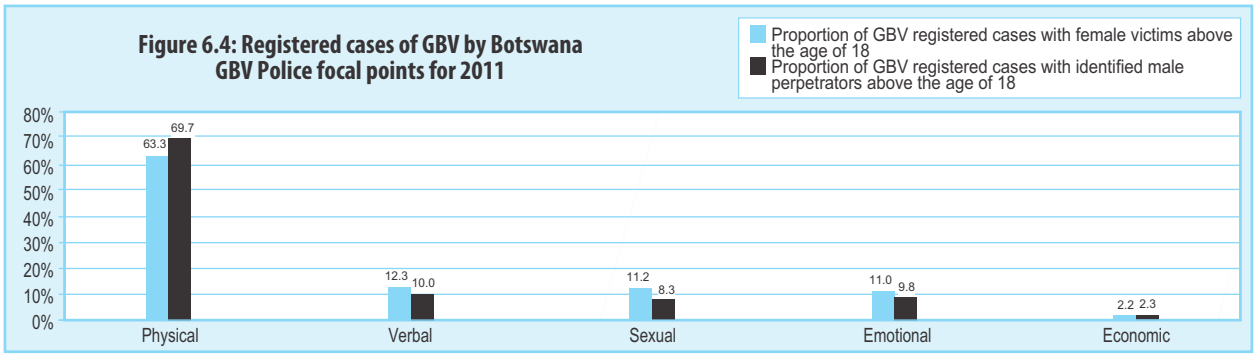
Table 6.3: Breakdown of registered GBV cases by type		
Form of violence reported	Number of GBV registered cases with female victims above the age of 18	Number of GBV cases with identified male perpetrators above the age of 18
Physical	5167	5697
Verbal	1008	815
Sexual	914	682
Emotional	898	798
Economic	178	185

Source Botswana Police GBV focal point annual report 2011.

Table 6.3 shows that the number of cases per the BPS categories for GBV. BPS categorises cases into physical, verbal, sexual, emotional, spiritual or economic GBV. Physical cases reported to police include cases of common assault, unlawful wounding, murder, attempted murder, grievous harm, Assault Occasioning Actual Bodily Harm (AOABH) and affray. Verbal abuse includes using insulting language or common nuisance. Sexual abuse includes rape, attempted rape, defilement, incest, indecent assault on females and indecent assault on imbeciles. Emotional violence includes intimidation, threats to kill, malicious damage, stalking, arson and obtaining by false pretences. Economic violence includes failure to supply necessities, failure to comply as defined in the Domestic Violence Act and obtaining by false pretences.

A total of 5167 women reported experiencing physical abuse in 2011, with common assault featuring highest. Intimate partners murdered 57 women above the age of 18. An additional seven suffered attempted murder. Over a thousand (1008) cases involved verbal assault of victims aged above 18. Most of the cases (623) involved the use of insulting language.

Police recorded 914 sexual assaults of females above the age of 18; 836 involving rape. The majority of emotional violence cases reported (428) involved threats to kill. Malicious damage to property- 261 cases - constituted the second highest form of emotional GBV. Obtaining by false pretences constituted 178 cases. Failure to comply was the most common form of economic violence (148 cases).



Source: Botswana Police GBV focal point annual report 2011.

Figure 6.4 shows in percentages the forms of GBV reported to BPS in descending order: physical (70%) followed by verbal (12%), sexual (11%), emotional (11%) and lastly economic (2%). In contrast (see Figure 3.11) the prevalence and attitudes survey results show emotional violence as most common form of GBV followed by economic then physical and lastly sexual violence in the 12 months before the survey. *This indicates that although emotional violence in the main form of violence experienced by women in Botswana according to their own assessment, they do not report this to the police even though such a category exists in police data.* The non-reporting of emotional violence may be due to a lack of awareness within the public that such a category for crime exists; hence few victims actually report it. This could also be the case for economic violence. In contrast the public is likely to be more aware of physical violence and assault as a crime hence the higher reporting of this form of violence to police. This points to the need for greater awareness by the public of the different forms of GBV for which redress can be sought, as well as a greater emphasis on psycho-social support and services.



Sharing knowledge during the GBV Pitso, Maun in Botswana, Nov 2011.
Photo by WAD

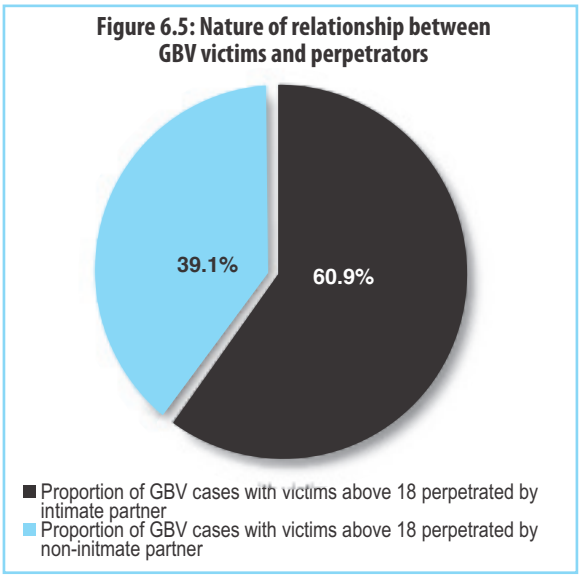
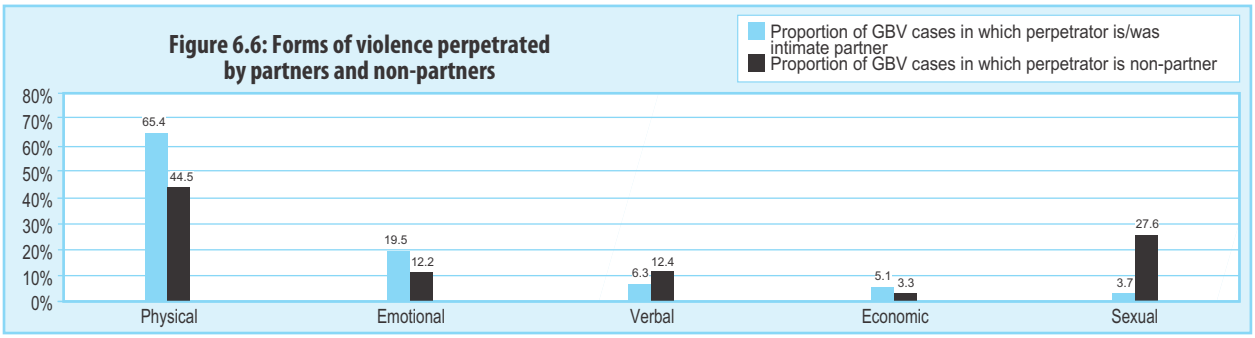


Figure 6.5 shows that almost three in every five cases of GBV reported by women above 18 involve intimate partners. This confirms the findings from the survey that GBV is primarily a domestic phenomenon rooted in unequal power relations. The survey findings showed that IPV is the most common form of violence experienced by women in their lifetime (62.8%) and even in the 12 months prior to the survey (28.9%).



Source: Botswana Police GBV focal point annual report 2011.

Figure 6.6 shows IPV reported to the police in descending order: physical (65%) emotional (20%), verbal (12%) and economic abuse (5%) and sexual 4%. The low reporting of sexual IPV by partners particularly husbands can be attributed to the gap in Botswana's legislation. The Botswana law does not criminalise marital rape. This could result in the women who experience it not coming up to report it. Apart from the law, conservative social norms support sexual entitlement to follow marriage as shown by the results from the attitudes survey. Almost half of the women (45.7%) and men (51.2%) participating in the survey said a woman cannot be raped by her husband. Thirty seven percent of women and 49% of men agreed that a woman could not refuse to have sex with her husband.

Physical (45%) followed by sexual (28%) constituted the highest proportion of non-partner GBV reported to the police. There is higher reporting of non-partner sexual violence compared to partner sexual violence. Non- partners perpetrated 797 cases of sexual violence compared to 167 IPV cases of sexual violence. These figures must be interpreted against the background that Botswana does not recognise marital rape.

Under reporting: comparison between the prevalence survey and police data

To understand the extent of under-reporting of GBV WAD and GL compared the prevalence of GBV as reported to the police with the self- reported prevalence in the survey.

The prevalence of police reported cases is derived by dividing the actual number of cases by the 2012 population estimate for women aged 15 years and above. Statistics Botswana is still analysing the results of the 2011 census, but has released a preliminary overall figure of million Batswana. Best available estimates are that that there are 683,127 women in the 15 years and above age groups and 682,473 men in similar age groups.[41]

Table 6.4: Prevalence of GBV as reported to Botswana Police Services focal points

Form of violence reported	Number of cases reported with female victims above 18	Population estimate	Prevalence of form of GBV based on police statistics (number of reported cases/population) %
GBV	8165	683127	1.20
IPV	4499	683127	0.66
Physical IPV	2994	683127	0.44
psychological(emotional +verbal)	1160	683127	0.17
Economic	228	683127	0.03
Sexual	167	683127	0.02
Non-partner sexual violence	797	683127	0.12

Source: Gender Links, BPS.

[41] Source: The CIA Word Fact Book: Botswana . Accessed from https://www.cia.gov/library/publications/the-world-factbook/geos/bc.html

Table 6.4 shows that according to the police reports about one percent of the women in Botswana from age 15 and above had experienced and reported some form of GBV in 2011. Less than one percent of women in this age group reported experiencing physical, psychological, economic and sexual IPV perpetrated by their current or most recent intimate partner.

Table 6.5: Comparison of police reporting and survey statistics

	Prevalence of different forms of GBV reported to police (number of reported cases/population) %	Survey statistics for past 12months
GBV	1.20	29
IPV	0.66	28.9
Physical IPV	0.44	13.3
Psychological(emotional + verbal)	0.17	19.6
Economic	0.03	16.3
Sexual	0.02	5.1
Non partner sexual violence	0.12	2

Source: Gender Links, BPS.

Table 6.5 shows that the prevalence of GBV as reported by police statistics is substantially lower than the prevalence reported through the survey. The prevalence of GBV reported in the survey is 24 times higher than that reported to the police. The prevalence of IPV in the survey is 44 times that reported to police in 2011 The prevalence of non-partner sexual violence in the survey is 17 times more than that reported to police. These statistics show that a very high proportion of violence still goes unreported.

Extent of reporting GBV in lifetime

Another way of looking at under-reporting of GBV is through responses in the prevalence survey to questions on whether or not women reported their experiences to the police. The survey asked women who reported experience of physical IPV and rape in their lifetime whether they reported the incidents to the police or health facility.

Table 6.6: Extent of reporting GBV in lifetime

Criteria	%
Proportion of ever partnered women who were physically abused, injured and who sought medical attention in lifetime	4.7
Proportion of ever partnered who were physically abused and who reported abuse or threats to police in lifetime	7.1
Proportion of all women who were raped and reported incident to police in lifetime	1.3
Proportion of all women, who were raped and who sought medical attention in lifetime	1.6

Source: Gender Links, BPS.

Table 6.6 shows that only 4.7% of women physically abused and injured by an intimate partner sought medical attention because of the injuries. Seven percent of women injured reported the abuse to the police. One percent of women raped reported this to the police. A higher proportion (1.6%) of women raped sought medical attention.

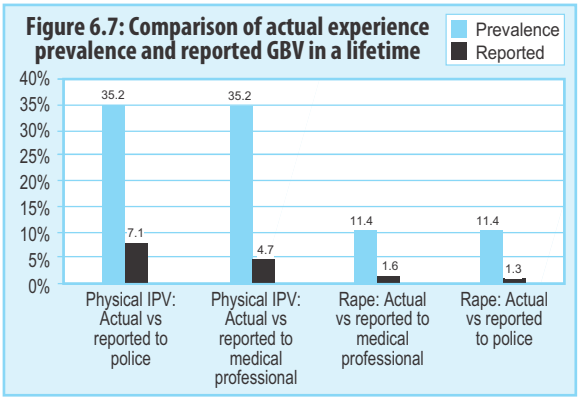


Figure 6.7 shows that there is a huge underreporting of physical IPV and non-partner rape, both to the police and health care facilities. Women were more likely to report physical IPV to police than seek medical help for the injuries sustained. Only one in every five women who were physically abused and injured by their intimate partner reported to police while only one in seven women physically abused sought medical help for the injuries.

The extent of underreporting of rape to the police was even higher than that of physical IPV. Only about one in nine women raped reported it to the police. Members of the reference group posited the following potential reasons why women do not report:

- The response and support services do not deal with women experiencing violence in a sensitive manner.
- Culturally it is a taboo, women should not expose their husbands.
- Women do not want to lose their homes and support.
- Such matters are settled within communities and families.
- Women who experience violence do not want to jeopardise their relationships.

Extent of reporting GBV in past 12 months

The survey asked women who reported experience of physical IPV and rape in the 12 months before the survey whether they reported the incidents to the police or health facility.

Table 6.8: Extent of reporting GBV in past 12 months

Criteria	%
Proportion of ever partnered women who were physically abused and who reported abuse or threats to police in past 12 months	4.0
Proportion of ever partnered women, who were physically abused by partners, injured and sought medical attention in past 12 months	2.5
Proportion of all women who were raped and who reported to police in past 12 months	0.5
Proportion of all women who were raped and sought medical attention in past 12 months	0.3

Table 6.8 shows that in the 12 months before the survey, four percent of the women experienced IPV injuries and reported this to the police. Three percent of women experienced IPV, injuries and sought medical attention for the injuries. Less than one percent of women were raped and reported this to police or sought medical attention.

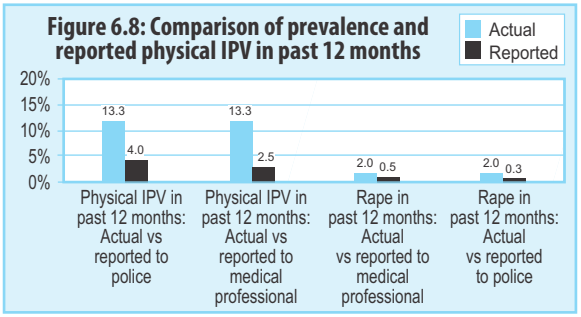


Figure 6.8 shows underreporting of physical IPV and rape in the 12 months before the survey. One in every three women physically abused reported to the police while only one in every five women physically abused sought medical attention.

Women reported rape less than they reported physical IPV. One in every four women raped in the 12 months to the survey reported to police while one in six of the women raped sought medical attention after rape.

Withdrawal of cases

Table 6.9: Withdrawal of registered GBV cases at police by female victims above the age of 18

Form of violence	No. of cases withdrawn
Physical	554
Emotional	70
Sexual	65
Verbal	64
Economic	24
Total	**777**

Table 6.9 shows that a total of 777 female victims above the age of 18 withdrew cases from police records in 2011 (compared to the 8165 cases reported). While these cases may not all have been reported that year, this suggests a withdrawal rate of about 9.5%. Physical GBV cases (554) constituted the highest number of cases withdrawn.

Reasons for the withdrawal of cases given by the Botswana police include the following:

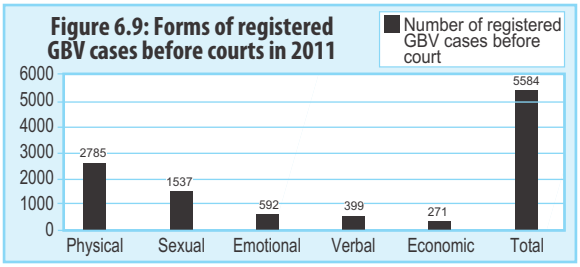
- Fear of victimisation by the alleged perpetrator.
- Some victims prefer out of court resolutions. This may include dealing with the matter at home or before the headman of arbitration. Most parties have been reconciled at the customary courts.
- Reconciliation between victim and perpetrators within intimate relationships.
- Some perpetrators show remorse and others promise to give victims compensation for withdrawing the case.
- Insufficient evidence because cases are reported too late and without medical proof.

Challenges experienced by police GBV focal points in dealing with cases in 2011 included:

- Shortage of transport making it difficult to access other policing areas.
- Shortage of office accommodation to provide counselling.
- Inefficient maintenance of registers because focal points sometimes assigned to other duties.
- Station commanders have not trained in GBV response.
- Some reports are made when there are no GBV focal points on duty.

Registered GBV cases before courts in 2011

The GBV focal points in the police follow the progression of GBV cases and record their status in registers. In 2011, 5584 cases of GBV went before courts.



Source: Botswana Police GBV focal point annual report 2011.

Figure 6.9 shows that the majority of cases were physical (2785), followed by sexual (1537), emotional (592), verbal(399) and lastly economic(271). The GBV focal points use the GBV registers to record the results of court proceedings on registered cases.

Table 6.10: Registered GBV Cases prosecuted in 2011

Form of GBV	Number of GBV cases before court	Number of GBV cases prosecuted	Number of GBV cases convicted	Number of GBV cases acquitted
Sexual	1537	158	93	65
Physical	2785	1319	1178	141
Emotional	592	344	294	52
Economic	271	62	31	31
Total	**5185**	**1883**	**1596**	**289**
Percentage	**100%**	**36.3%**	**31%**	**5.5%**

Source: Botswana Police GBV focal point annual report 2011.

Table 6.10 shows that of the 5185 cases of sexual, physical, emotional and economic violence before the courts 1883 cases (36.3%) resulted in prosecution 31% in convictions, and 5.5% in acquittal.

Table 6.11: Rate of prosecutions and convictions of GBV cases by courts

Form of GBV	Prosecution rate	Conviction rate
Physical	10.3	58.9
Emotional	47.4	89.3
Sexual	58.1	85.5
Economic	22.9	50.0
Total	**36.3**	**84.8**

Source: Botswana Police GBV focal point annual report 2011.

Table 6.11 shows that sexual abuse cases had the highest prosecution rate while physical GBV had the lowest prosecution rate. Almost three in every five (59%) of sexual cases were finalised while only a tenth (10%) of physical cases were finalised. The conviction rate was highest with emotional abuse and the lowest for economic violence. Eighty six percent of the sexual cases resulted in conviction.

Globally, conviction rates for GBV are notoriously low. By these standards, Botswana is doing well. The country also has an excellent tracking system. However, there is room for improving both prosecution and conviction of GBV cases. These numbers also have to be viewed against the backdrop of under- reporting. *With a prevalence rate of nearly 30% over the last year (according to the survey) Botswana had 204 938 women who experienced violence. Of these, only 1596, or 0.6% got relief through the courts. This means that men who perpetrate violence literally get away with it.*

Directorate of Public Prosecution (DPP)-Attorney General's Chambers

This department receives dockets of specific cases from the police depending on the nature of the offence. Each prosecutor is allocated dockets of cases to prosecute and upon completion of these cases the dockets are sent back to the Police with notes on the outcome of the case. Records of cases dealt with are available and computerised in the form of a case management system. However, as with the police statistics there is no information on the victims. However details on the gender and age of both perpetrators and victims can be accessed from the police dockets held by prosecutors.

Department of Social Services (DSS) - Ministry of Local Government

This department does not deal directly with cases of GBV but do attend to people who come to their offices seeking assistance. In such situations, they provide immediate counselling and refer clients for continuous counselling. Most of the people who visit their offices directly are from Gaborone and the neighbouring villages. The department collects statistics from the districts for compilation. The department compiles the statistics from the district, grouping those on GBV separately on a monthly basis. The compiled statistics are currently for internal use and there are no published records. Plans to publish the statistics and share with stakeholders are underway. However, detailed data on the victims such as gender and age is available at respective district offices and kept in confidential case files.

Tribal Administration-Ministry of Local Government

The Customary Courts play an important role in addressing cases of violence at the community level. They also provide counselling and reconciliation. Complaints reported at local level are captured in the case record book. Like most law enforcing departments in government the Customary Courts focus more on the perpetrator than the victim and hence there is more detailed information on the perpetrator than the victim. The case record book has all the details pertaining to the case like the name of the offender, the type of offence and how the case was dispensed with.

Types of violence often dealt with include assault common, common nuisance; assault occasioning actual bodily harm and use of insulting language. The information is then summarised and the returns are

forwarded to headquarters on a monthly basis. Summarised information is available at national level and is based on returns received from the communities. More detailed information on cases of violence can be obtained from the Customary Courts in the communities.

WAD and GL visited and collected data on GBV from Broadhurst Customary Court in Gaborone. The data presented shows 316 cases of offences in which women were victims. It provides a glimpse of how the customary courts work.

Table 6.12: GBV cases seen at Broadhurst Customary Court in 2009

Offence	Number of cases	%
Theft	132	41.8
Assault common	68	21.5
Assault occasioning actual bodily harm	39	12.3
Use of insulting language	29	9.2
Common nuisance	28	8.9
Stealing from a person	18	5.7
Affray	2	0.6
Total	**316**	**100**

Source: Broadhurst Customary Court.

Table 6.12 shows that over a fifth (21.5%) of the cases involved assault, common assault and occasioning actual bodily harm which could include incidents of physical IPV. One in eight (12%) of cases involved the use of insulting language which could include incidents of emotional violence.

The data collected at the customary court does not include the relationship between the complainant or "victim" and her perpetrator so it is difficult to establish if the cases were domestic or not. This is a weakness in the data collection system that needs to be addressed.

A comparison of the number of cases seen at customary courts with cases at police or at organisations like the Kagisano Women's Shelter shows that fewer survivors turn to and seek justice at the customary courts compared to women who seek help from the formal systems. This is a positive sign as it suggests that the criminal justice system is accessible to women.

Ministry of Health Sexual and Reproductive Division

Information is compiled from reports submitted by health facilities to the Health Statistics Unit on a monthly basis. This information is coded, analysed and compiled into statistical data and published in annual reports. The data covers victims of assault classified by morbidity or mortality depending on the outcome of the case. This data on assault is further classified by type of assault; whether it was by a sharp object, a gun, bodily force or by drowning. Details on the age and gender of the victim are also provided.

The information at this level is presented in a summarised format but details can be accessed at facility level. The details would include the demographic background of the patient as well as the type of treatment given and referrals. For instance in the case of rape, health facilities are required by law to provide Post-Exposure Prophylaxis (PEP) to persons who have been raped in order to minimize the possibility of the survivor being infected with HIV.

The Botswana Government through the Ministry of Health has put in place a National Sexual and Reproductive Health Programme (NSRHP).

Policy Guidelines and Service Standards for Sexual and Reproductive Health

The goal of the NSRHP is to improve the sexual and reproductive health of all people living in Botswana. NSRHP's primary focus is on reaching out to adolescents/youth and men, and making health services youth friendly, as well as, gender sensitive.

One of the policy documents developed within the NSRHP is the Policy Guidelines and Service Standards for National Sexual and Reproductive Health Programme. Service standards and guidelines are intended to be used by programme managers, implementers, trainers, supervisors, and

service providers within the health sector as a tool for delivering quality care measures. The document outlines the steps on how to offer and deliver services.

Management of survivors

According to the service standards the management of GBV survivors should include:

- Counselling and rehabilitation.
- Medical treatment of presenting symptoms.
- Screening for STI/HIV and AIDS especially for rape cases.
- Post Exposure Prophylaxis (PEP) sexual violence.
- Emergency contraception in case of sexual violence
- Referral as necessary.
- Legal protection.

Challenges

The service guidelines refer to some challenges in the existing facilities in managing survivors of GBV. Challenges identified as in existing health facilities are:

- Inadequate knowledge/skills among health services providers.
- Limited data and statistics on causes and impact of SRH related issues including GBV
- Inadequate capacity of health facilities to manage gender-based violence.
- Inadequate coordination among key stakeholders in SRH and gender-based violence.
- Inadequate counselling services and follow up.
- Inadequate agencies involved in the prevention and management of gender-based violence.
- Absence of male user-friendly services.

Next steps

The services standards propose measures to ensure the delivery of better care to GBV survivors. These include:

- Orient the health system to respond to the prevention and management of gender-based violence, sexual reproductive health issues, promotion of cultural change and improvement of the legal protection of survivors.
- Train health workers to be gender-sensitive in providing health services.
- Undertake gender-sensitive initiatives to address sexual reproductive health issues including GBV.
- Promote gender-based operations research.
- Develop appropriate treatment programmes for survivors of violence and rehabilitation for perpetrators.
- Strengthen national and community response to prevent GBV in SRH.
- Health facilities should be equipped with information, examination and laboratory facilities for detection.
- Management of reproductive health related conditions and gender-based violence.
- Establish referral mechanism to create linkages between health system, communities, law enforcement and legal systems.
- Health facilities should be equipped with laboratory facilities for STI/HIV and AIDS screening, (especially to cater for rape cases).
- Guidelines should be made available for health service providers for the provision of:
  - Counseling and support to survivors
  - Records and referral procedures
  - Management procedures (identifying diagnoses and treatment)

Source Family Health Division publication available at http://botswana.unfpa.org/drive/SRHPolicyGuidelinesandServiceStandards.pdf

Statistics Botswana Demographic Statistics Unit

Crime statistics are compiled by Statistics Botswana under the Demographic Unit. Information is accessed from records filed at the High Court. These records cover both civil and criminal cases. The information complied is on the perpetrators and not the victims. The records cover cases, which have been prosecuted, including those that have been withdrawn. The monthly returns are supposed to be published into an annual report.

The unit is currently working on the 2006 Crime Statistics Annual Report. The record management system was put in place a few years back. The Crime Statistics do not specifically cover GBV. The classifications include homicide offences, sexual offences, murder, assault, harassment and related

offences. There is need for a specific section on GBV in the annual crime report.

Information compiled at national level by various government departments is not as detailed as the one found at facility level. The initial information sent from the facilities or police stations is more detailed. At national level, the information from the facilities is summarised and published as annual returns.

WAD

The coordination of services for management of violence cases and violence prevention by multi-sectorl networks at the community level is essential for influencing a real change in a community on the issue of GBV. The Women's Affairs Department has therefore initiated a process of establishing a Gender Based Violence Referral System among key service providers for GBV victims and survivors. This is done as a component of the integrated approach to combating GBV and aims to improve co-ordination and collaboration among different stakeholders to enhance efficiency and adequacy in delivering GBV services. A study was conducted to establish the GBV referral networks that exist in Botswana, their adequacy and gaps.

This was followed by the ongoing stakeholder consultations that have also been key in this process. These consultations facilitate ownership and contribute to the development of an implementable system. The referral system is being piloted in Maun and Mochudi and the results of the pilot exercise will be proposed for national roll-out.

Different government sectors have been positioning themselves to respond to and prevent GBV. The Ministry of Health has developed protocols and service standards for prevention and management of gender based violence for health care providers. The Botswana Police Service has developed a handbook and training curriculum on Effective Police Responses to Violence against Women.

The Kagisano Society Women's Shelter Project (KSWSP)

Founded in 1989 KSWSP in Gaborone provides shelter and counselling for victims of gender based violence. It was the first shelter of its kind in Botswana and has been providing services to the people in the catchment area for over a decade. The project provides temporary accommodation, legal and medical assistance to women and their children. The project operates a drop in center and a shelter in Gaborone as well as a drop in centre in Molepolole. The organisation compiles information on the victims from the cases attended to by individual counsellors.

Gaborone Drop In Centre and Shelter

Access to services by survivors

During 2010, 396 clients accessed counselling services offered at the Drop-In-Centre (DIC) in Gaborone.

Table 6.13: Gender distribution of clients KSWSP 2010

	First quarter	Second quarter	Third quarter	Fourth quarter	Total	% of total clients
Female	99	98	51	55	303	76.5%
Male	30	29	19	15	93	23.5%
Total	129	127	70	70	396	100%

Source: The Kagisano Society Women's Shelter Project 2012.

Table 6.13 shows the gender distribution of the clients of the shelter. In 2010, women constituted 76.5% women of the clients compared to 23.5% who were men.

Challenges

The organisation has been experiencing a decrease in the number of clients served at the DIC since 2007. While the exact cause in this reduction of uptake of services has not been formally investigated, it could be attributed to the reduction in staff at the shelter. The result in high staff turnover has been a reduction in counselling capacity as well as a reduction in outreach activities. Throughout the year, interns have helped to ease some of the overflow of clients, but have not been able to completely fill that gap. The need for increased counselling capacity continues to be a challenge for the organisation.

Molepolole DIC

In 2008, three Botswana Peace Corps Volunteers conducted an assessment of the Molepolole DIC. The assessment showed a need to open a centre that supported victims of Gender Based Violence. After talking to many community stakeholders, such as Chiefs, Kweneng Gender Committee, police officers, the Magistrate Court and the hospital, it was decided that such an organisation was needed in Molepolole.

The centre contacted the KSWSP in Gaborone and asked to be the umbrella organisation to help with both financial and technical support. The partners agreed that the counselling and outreach-centre in Molepolole would be an extension of the larger organisation in Gaborone.

With help of a grant from Academy for Educational Development (AED), the KSWSP Molepolole Drop in Centre was officially opened in December of 2009. The office started operating in 2010. With the assistance from Peace Corps Volunteers in the area, the Drop In Centre has been able to build a strong foundation of support with the community and complete many milestones set by KSWSP and the other donors, including; AED, UNFPA, and the Ministry of Youth.

The organisation has a strong working relationship with the Peace Corp Volunteer in the area and in other villages in the Kweneng District, mainly to utilise their individual skills to help build technical, organisational, and management capacity.

Services provided include:

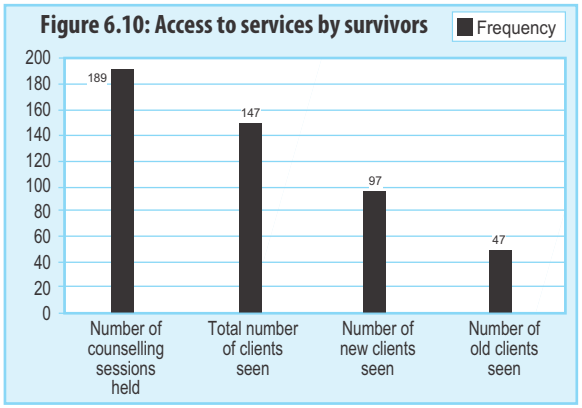
- Community outreach activities on gender based violence
- Counselling and referral services
- Organising and implementing youth activities and life skills lessons, and
- Collaborating with other stakeholders in the community including the Gender Committee and DMSAC.

Over the past two years, the Molepolole DIC has achieved the following:

- Facilitated public discourse on GBV in Molepolole and surrounding villages in the Kweneng District.
- The DIC's client base has grown and more people are aware of the services provided.



- The school workshops have been a great way to reach young people and discuss issues relating to Gender Based Violence and HIV and AIDS and all aspects of healthy relationships. The young people seem eager to discuss these issues and are enthusiastic about asking questions.
- In 2010, the Cultural Dialogue that was a huge success and one of the first attempts made in Molepolole to engage custodians of culture and village elders in such a discussion. This activity strengthened the DIC's relationship to the immediate area and legitimised their work in the eyes of Dikgosi. The Dikgosi has requested that the DIC conduct further workshops.
- The centre had drama competitions, out of school youth projects, girls leadership project in 2011. One of the success stories was in 2010 where the office hosted a debate competition for junior secondary schools. The office is also effectively involved in the district committees that embark on stopping GBV.





Participants at the GBV Pitso in Maun, Botswana, Nov 2011. *Photo by WAD*

Figure 6.10 shows the numbers of clients that came in for counselling sessions in 2011. Overall, 147 clients came in for counselling for different issues. The majority (97) of clients seen were new clients. Forty seven clients were first seen in the previous financial year.

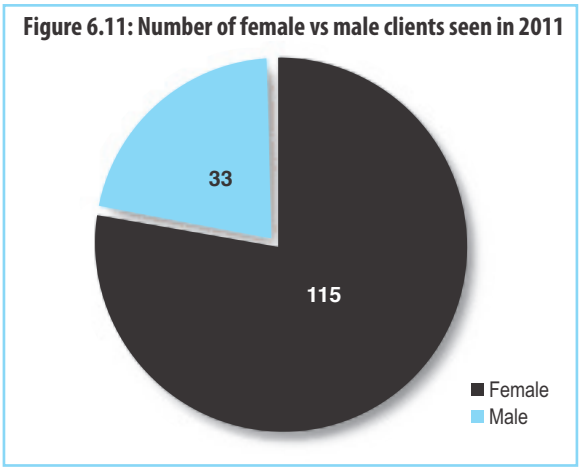


Figure 6.11 shows that the majority (78%) of clients seen at the Molepolole DIC are women. One hundred and fifteen women and 33 men received counselling in 2011.

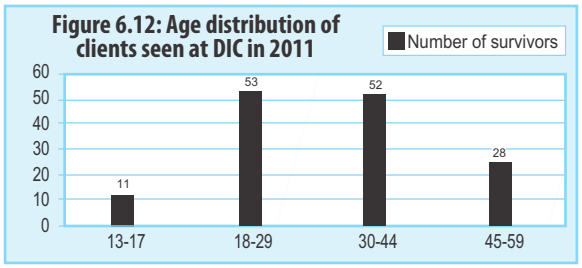


Figure 6.12 shows that the majority or clients seen at the DIC are in the 18-23 age group followed by the 30-44 age group. This finding correspond to the survey findings that show women in the 18-29 age group as being most likely to experience GBV. The profiling of clients seen is important to understand GBV risk groups and inform target groups in prevention interventions.

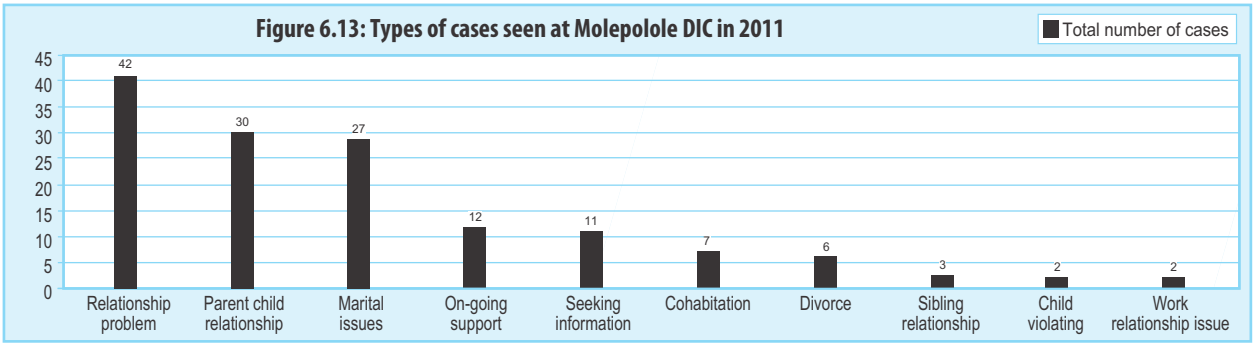


Figure 6.13 shows that the most common cases reported at the Molepolole DIC in 2011 were relationship problems. Forty two cases of relationship problems were dealt with. Other GBV related cases included marital issues, on-going support, cohabiting and divorce.

Women Against Rape, Maun

Women Against Rape (WAR) is based in Maun, in the north-west of Botswana. The NGO supports abused women and children and addresses the issues that contribute to their abuse, including perpetration rehabilitation for men. A group of women founded WAR in 1993 in Maun, Ngamiland District in response to the rape of three Bushmen women by white farmers. The perpetrators of these rapes were never prosecuted. The organization was founded on the ethos of activism and volunteerism, which continues to colour its identity, management, and activities.

Target

The key target of the programme are the women and men from the local community of Maun and Ngamiland. Key stakeholders include the police, hospitals and courts. WAR has learnt of the importance of involving both men and women as community activists and to guard the socialisation of children through school programmes.

Programmes

WAR offers support to survivors of gender-based violence through the following programmes:

Counselling

WAR counsels the victims, victims' families, and perpetrators of gender-based violence in order to provide complete healing and prevent further abuse.

Legal and Medical Aid

After an incidence of gender-based violence, the victim must get proper treatment at the hospital, report what happened to the police, see a social worker, and possibly go to court.

Psychosocial Support

WAR offers support to all survivors of GBV.

First Stop Programme

This programme is a network of volunteers who represent WAR in their communities. They receive training in gender-based violence, police protocol, and basic counselling skills and act as the eyes, ears, mouths, and hands of WAR. They liaise with WAR as much as possible and refer people in their communities to WAR whenever necessary.

Emergency Accommodations

WAR operates a safe house to provide shelter and a place to heal for the victims of gender-based violence.
Source www.womenagainstrape.co.bw

Lifeline Botswana

Lifeline Botswana was established in 1999 as a community based NGO under the guidance of Lifeline International. The organisation offers free and

confidential counselling services to the community. Counselling services are provided through face to face and telephone interviews. Where necessary, the clients are referred to relevant organisations for further assistance. Lifeline also empowers individuals by training them in life skills.

Statistics on the cases dealt with are captured on a monthly basis. Since October 2010 the statistics are now disaggregated by gender. The cases dealt with cover a wide range of social problems including gender based violence, HIV and AIDS, depression, anxiety, stress and employment related problems. From April 2008 to March 2009, the organisation handled a total of 687 cases.

Table 6.14: Lifeline Counselling Clients By Sex From April 2008 To March 2009

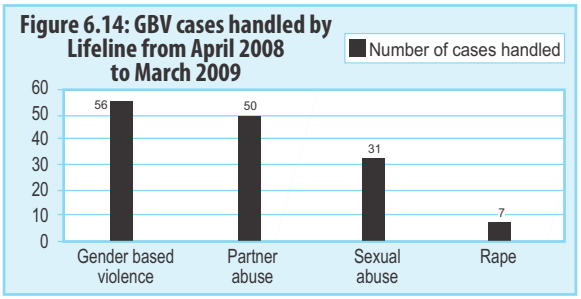
Offence	Number of clients	%
Male	256	37.3
Female	384	55.9
Telephone	47	6.8
Total number of clients	687	100.0

Source: Life Line Botswana (2010) 2009-10 Annual Report .

Table 6.14 shows that the majority of counselling sessions conducted (93.2%) were face to face. Only 6.8% of sessions were conducted over the phone. The majority of the face to face sessions (60%) were with female clients. Worth noting is the fact that men constitute a significant proportion of the clients seen at Lifeline.

The range of cases handled by Lifeline is however very broad. Between March 2008 and April 2009, out of the 687 cases handled, 144 of them were classified as GBV related.

Figure 6.14 shows that the majority of cases (56) had been classified as GBV. Fifty cases were classified as partner abuse while 31 cases were classified as sexual abuse. Seven of the cases handled were rape cases.



Source:Life Line Botswana (2010) 2009-10 Annual Report.

The classification of recorded cases is not exclusively definitive. Some of the categories overlap, for instance, cases recorded as GBV could include the other separate categories of abuse such as sexual violence and partner abuse. Similarly it is unclear how an individual presenting multiple problems would be classified. All these could be classified under GBV, depending on the parties involved. Due to this type of classification, there is a possibility of an under or over count of GBV cases. It is imperative for Lifeline to establish a standard way of classifying cases and ensuring that the personnel entering data adhere to the specified standards. There is need to do away with the umbrella category GBV which brings all the forms under one category and limits understanding on the range of experiences by clients.

Stepping Stones International

Stepping Stones International (SSI) is a non-governmental organisation working with youth, but assists survivors of GBV with referrals and linkages to essential services of police, health care specialists, government social workers, community support persons, counselling/psycho-social support, skill development and occasionally capacity building targeting income generation.

Table 6.15: Number of GBV cases disclosed			
	Total	Male	Female
GBV cases disclosed	8	2	6
Cases with Police	5	0	5
Incest Cases	1	0	1
Rape Cases	6	1	6
Defilement Cases	1	0	1
Repeat Cases	3	0	3
Referrals to Legal Support	6	1	6
Success rate with criminal justice system	0	0	0
Pilot Referral System Project	1	n/a	n/a
Training Curriculum for Police	1		

Source: Stepping Stones, Mochudi .

Key outcomes to date include: increase in case disclosure; increase in GBV support in Mochudi; successful Suicide Intervention; increased community awareness; support from Police Station Commander and officers; increased partnership with trained drama therapy experts; leveraged community support; improved partnerships at local and international level.

The next steps for Stepping Stones International are as follows:

- Work closely with WAD to assist in technical guidance as well as facilitate the setting up and monitoring and evaluation of the pilot referral system.
- Improve internal monitoring, evaluation and documentation of GBV cases at SSI.
- Conduct research on GBV, in particular sexual abuse of children.
- Leverage more financial, political and international support.
- Continue to roll-out awareness campaigns in multiple communities.
- Capacity build/train at all levels of the system (i.e. police in working with children in ways in which they prevent secondary victimisation).
- Create an effective action plan for moving forward.
- On-going capacity building and support for human resources.

Reference to response and support by politicians

The political content analysis examined the extent to which politicians referred to GBV response and support.

Figure 6.15: What politicians advise survivors of violence

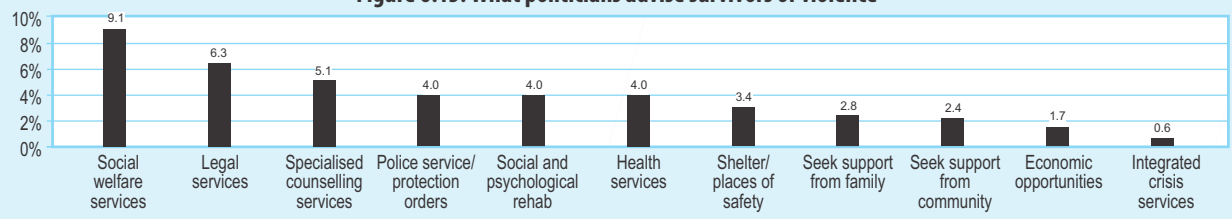


Figure 6.15 shows that most speeches that mention GBV indicate social welfare services as the proposed support system for survivors of GBV. Six percent of the speakers referred to legal services while 5% referred to specialised counselling. Four percent of speeches refer to police services, social rehabilitation

and health services. The least referred to support structures are integrated crisis services as these do not exist in Botswana. On the positive side politicians acknowledge that support to survivors of violence is a state responsibility rather than just the responsibility of the family or community. What is not clear is whether adequate state resources measure up to the need.

Conclusion

The findings from the survey and administrative data provide a wealth of evidence that GBV is under-reported by a factor of up to 24; that 10% of cases reported are withdrawn; that only a third of cases before the courts result in prosecution. Even though the majority of cases prosecuted result in conviction, these constitute less than one percent of the actual need, considering a prevalence rate of 30% over the last year as established by this study.

The findings from this section show that although women and men acknowledge that there are protective laws in Botswana, they have little knowledge about the actual detail in the laws. More efforts have to be put into disseminating information on the Domestic Violence Act, the Penal Code sexual offences sections and on protection orders. This information could be disseminated through radio which is the main identified source of information. Other media such TV and newspapers also need to be utilised to greater extent. Community leaders should also be empowered to disseminate information at their community meetings.

The Botswana Police Services, KSWSP and Lifeline acknowledge GBV and its different forms. Data on GBV is being categorised in ways generally useful in making inferences about the use of services by GBV survivors. They also disaggregate data by sex and it is possible to ascertain the actual cases of violence against women.

Although there are other government departments such as the Department of Social Services and Ministry of Health and NGOs such as WAR dealing with GBV cases, these could not provide data. For the purposes of programming and accountability to the proposed GBV Referral System is expected to create an accessible national database of all GBV services providers. All stakeholders will be required to report regularly on their programmes and statistics.

Another gap identified in this review is the fragmented response to GBV among the different stakeholders. For example, the number of cases reported to police differs significantly from that at KSWSP or Lifeline. The establishment of an effective referral surveillance system is critical in understanding fully how survivors access services. The current picture is that more cases are reported to police and very few of these cases access counselling or shelter services. It is impossible to ascertain the use of health services particularly access to PEP by sexual assault survivors and whether they adhere to the treatment course.

With a GBV prevalence rate of close to 30% over the last year as established by the survey in this study, more than 200,000 women would have been in need of support services of some kind. With only two NGO shelters for abused women in the whole of Botswana and advocacy through the Domestic Violence Act for provision of the establishment of facilities for protection, there is need to develop facilities for safety of GBV victims.

CHAPTER 7
Prevention



Pastor Taukobong from Selebi Phikwe, being interviewed by BTV during the Sixteen Days of Activism in Gaborone, Botswana. *Photo by Roos van Dorp*

Key facts

- ✓ Only 12% of the speeches by politicians that centred on, or mentioned GBV, focused on prevention. Politicians made these speeches at commemorative events like the Sixteen Days of Activism.
- ✓ Approximately half the women and men in the survey knew of events or prevention campaigns to end GBV.
- ✓ Only 16% of women and 18% of men had heard about the Sixteen days campaign in the 12 months before the survey.
- ✓ 8% of women and 10% of men had heard about the 365 days campaign in the 12 months before the survey.
- ✓ 7% of women and 8% of men participated in a march or event to protest against GBV.
- ✓ 63% of the women and 51% of the men aware of GBV campaigns found these campaigns empowering.
- ✓ Radio is the main source of information on GBV events and campaigns.
- ✓ The Centres of Excellence for Gender Mainstreaming in local government - a joint project of GL, WAD and 18 councils, provides a sustained way of cascading the GBV indicators project to the local level and starting a campaign to win the war war on GBV- community by community.



"My name is Kebareng[39]. My daughter was always my best friend. We shared everything in the house, the food, the bed, the good and the bad times. We came to Maun in 2006. She was doing form one at Sedie CJSS.

One day she went to school as usual and never turned up in the afternoon as she usually did. I drove to school to check on her. There was no one at the school. I was so worried. At around 6 pm I heard a car stopping outside. I went to the door and opened it; I saw a van full of students in uniform with three teachers. Two students held my daughter. She could not walk and I thought she was hit by a car. The two teachers took me inside the house. She told me an 18- year old classmate wearing boots had kicked her.

They went on to tell me the incident happened at around ten in the morning and my daughter was taken to the hospital. I took her to the pastor for prayer and then back to the hospital because she could not breathe well. After a week, I took her to the hospital and I called the young man's sister to discuss the issue. He received five strokes on the buttocks and told to keep on checking the condition of my daughter.

He never came back or phoned. I went to church and met him. He did not say anything to me. I stopped going to the church and my daughter refused to go to school because the young boy and his friends threatened to beat her. I went to school to tell the school headmaster. Furious, he asked me and asked me to take my daughter out of their school.

I went to Women Against Rape (WAR) for counselling. They promised to follow up the case but nothing happened. I sent my daughter to Okavango English Medium school.

One day she and her friends came home crying and reported that the boy who beat her was accusing her of influencing the other girls to turn him down when he asked them out. At that time I learnt that my daughter was in love with my neighbour's son who was much older. My daughter started to sneak out and disappeared from home for up to five days.

My neighbours would tell me that they saw her with a much older man. I asked WAR and the police to assist in searching for my daughter. The police took the young man with them for interrogation and he told them he started sleeping with my daughter when she was 13 and took her to his mother's place and that the mother is aware of their relationship.

My daughter, the young man, his parents, and I met. My daughter said she is in love with the man. She said she hates me and that I was a witch because I want to separate her from the man she loves. I received counselling and prayers from WAR. My daughter attempted suicide twice.

I thought of taking my daughter out of the expensive boarding school. Unhappy with the suggestion, I took

[39] Not her real name.

her to WAR again where she got counselling. She agreed to go to boarding school.

I took her to Popagano CJSS in Sepopa and asked the teachers if she could repeat form two. The first term she told me she did not like the school as it was far from me and too remote. I convinced her that distance does not matter, only her education. She is now enjoying the place.

When she came home for the holidays, she confessed to peer pressure influencing her behaviour. She asked me to forgive her. We both cried. I prayed and thanked God for answering my prayers.

My daughter has started Scripture Union at school and is preparing her first gospel album. During the holidays my daughter is always at home helping me. On Sundays she goes to the church and attends church activities. When she wants to go somewhere she asks for permission. Her behaviour has completely changed. She is guiding other students."

Kebareng's* story shows that young women are very vulnerable to GBV for various reasons including peer pressure, low self esteem and poverty. The prevalence study showed that nine percent of the women in the sample had experienced sexual harassment at school. The case study also shows why it is important to raise awareness and implement prevention strategies early.

This chapter explores prevention initiatives being implemented in Botswana and their effectiveness. Prevention intervention can be categorised in three ways[43], namely:

- ***Primary prevention***, which are interventions that are aimed at addressing gender- based violence before it occurs, in order to prevent initial perpetration or victimisation, targeted action aimed at behavioural issues and risk producing environments.
- ***Secondary prevention***, that happens immediately after the violence has occurred to deal with the short term consequences, e.g. treatment, counselling.
- ***Tertiary prevention*** focuses on long term interventions after the violence has occurred, in order to address lasting consequences, including perpetrator counselling interventions.

In this study, emphasis is placed on documenting primary and secondary prevention initiatives in the different arenas for action.

Arenas for action

The ecological model referenced earlier in this study provides the key arenas for action. These are:

- *Individual:* The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. Some of these factors are age, education, income, substance use, or history of abuse.
- *Relationship:* The second level includes factors that increase risk because of relationships with peers, intimate partners, and family members. A person's closest social circle-peers, partners and family members-influences their behaviour and contributes to their range of experience.
- *Community:* The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence.
- *Societal:* The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society.

Primary prevention

Primary interventions for GBV target the root causes at an individual, relationship, community and societal level. Strategies include:

- Political will and commitment to address GBV;
- Public awareness programmes;
- Using media to raise awareness on GBV.

[43] Centres for Disease Control and Prevention. Sexual Violence Prevention: Beginning the Dialogue. Atlanta, GA (2004) p. 3.



Former Minister of Labour and Home Affairs Letlhogonolo Peter Siele Siele receiving the Botswana Gender Barometer. *Photo by Roos Van Dorp*

Political will and commitment to address GBV

For a violence prevention strategy to be successful it has to be unified, coordinated, scientifically-informed, well-resourced and directed across all clusters of society, government departments and civil society. Political leadership should be committed to ending GBV and consistently and publicly denounce this scourge. Leaders should also facilitate and support necessary changes in community norms that influence GBV-related behaviours of boys and young men .

The Ministry of Labour and Home Affairs in 2011 conducted a national GBV "Pitso" (a platform for the Minister to engage with community members and stakeholder on GBV) in Maun from the 27-28 October 2011 using an interactive approach. The then Minister of Labour and Home Affairs, Honourable Peter Siele launched the "Pitso". Around 200 participants and stakeholders from around the country participated. The outcomes of the Pitso included the identification of emerging issues on GBV and discussions on areas of intervention with stakeholders and the public.

Unfortunately, leaders have not yet mainstreamed GBV into high profile events in the same way as they have HIV and AIDS. The political content analysis in this study showed that of the 192 speeches given by cabinet ministers, the president, mayors and council chairs in 2011, only 6% focused on GBV and another 9% mentioned GBV in passing. The speeches that focused on GBV largely took place during the Sixteen Days of Activism and or on other commemorative days. This points to the need to stretch the Sixteen Days of Activism campaign into a year long, 365 Day Action Plan to End Gender Violence. Of the speeches analysed, only 12% focused on prevention. This shows that political leaders in Botswana have a long way to go in putting prevention at the heart of GBV strategies.

Public awareness campaigns

Each year, several events are held to raise awareness on GBV and mobilise key stakeholders as well as the public to take action against violence during the Sixteen Days of Activism.

Key dates include:

- 25 November: International Day of No Violence Against Women and Children and the start of Sixteen Days of Activism Campaign.
- 1 December: World Aids Day.
- 10 December: Human Rights Day.



Take back the night march in Lobatse. *Photo by Keabonye Ntsabane*

Sixteen Days of Activism Against Violence Against Women and Children

The annual national commemoration of the Sixteen Days Campaign is spearheaded by the Women's

Affairs Department (WAD) and mobilises all stakeholders, as well as the general public, to come together and speak out. Each year the event is set in a different area in Botswana. In 2011, the commemoration took place in Shakawe and the year before in Nata, starting off with a march, followed by a public debate on the issues. In addition other government ministries and institutions, parastal and private organisations, NGOs and local communities normally conduct localised activities as a contribution to the annual national anti-GBV campaign.



Zoroga choir entertaining during the Sixteen days of life meeting in Nata village. *Photo by Vincent Galatlhwe*

The Sixteen Days of Activism on Violence against Women and Children campaigns in Botswana continues to grow as stakeholder involvement and participation increases. Stakeholders include government departments, civil society organisations, development partners, private sector and the media.

Prior to 2009 the national Sixteen Days commemorations mostly took place in the capital city Gaborone. In 2010 the then Minister of Labour and Home Affairs Honourable Peter Siele decided to move these commemorations to villages around the country. The 2010 and 2011 national commemorations in Nata and Shakawe villages respectively, mobilised communities in those locations from surrounding villages. A series of events in the villages resulted in mobilisation, engagement, education and feedback from community members on gender based violence, violence against women and children and the link with HIV and AIDS.

These included panel discussions with community leaders, viewing of the 'Molemo wa Kgang' TV show and sensitisation workshops for community leaders and other stakeholders on GBV and HIV and AIDS. After the national commemorations, plans were developed with stakeholders in those communities for continued engagement on GBV with the community. Stake-holder initiated activities were conducted around the country.

During the Sixteen Days of Activism on violence against women, NGO's also offer training to media on reporting on gender violence and inform the public on the services they offer. In the build-up to the Sixteen Days Campaign in 2011, GL trained 15 media practitioners on GBV and the campaign and how to report on issues of violence, give a balanced report and to make more women's voices heard in the media. Every year, GL also facilitates cyber dialogues; online chats that connect people from different SADC countries to discuss topic that relate to daily themes. Topics include GBV and economic violence, disability and GBV, tradition and the role of men in GBV, GBV, HIV and AIDS.

Local government

Local authorities are also using the Sixteen Days Campaign to educate and increase awareness on GBV in their communities. For example, during the Sixteen Days 2011, the Kweneng Gender Committee



Police officer leads participants of GBV March during Sixteen Days Commemoration in Nata. *Photo by Vincent Galatlhwe*

organised a "Black Thursday" vigil night in one of their sub-districts Gabane, in remembrance of all the women who had lost their lives due to GBV. Participants wearing black attended the march that led to the "kgotla", to share experiences and sign a banner stating "Ending GBV starts with me."

World Aids Day

World Aids Day is widely commemorated in Botswana, due to the severe impact of the epidemic on the country and its people. In 2010, HE President Seretse Khama Ian Khama stated in his key note address that prevention efforts needed to be stepped up, as the economy could not carry the Pula 1.3 billion cost to the Botswana's economy.

The President noted his concern about the gender gap in HIV and AIDS and called for gender sensitive responses. These remarks are encouraging, as gender is frequently not mainstreamed into HIV and AIDS prevention programmes.

Other forms of public education

The Government of Botswana continues to conduct different campaigns every year to raise awareness about gender based violence as a human right issue at the local and national level and to condemn any form of violence, especially against women and children. In this way, the country demonstrates its commitment of building a compassionate, just and caring society as stipulated in Vision 2016.

In addition to the GBV campaigns facilitated by Government in collaboration with civil society organisations and other partners, the following are some of the efforts in advancing public education on GBV issues:

- Simplification of the Domestic Violence Act 2008 and translation into the local language (Setswana) for community and stakeholder sensitisation purposes.
- Development of IEC materials on GBV and related issues.
- Addressing of meetings, workshops, conferences, and public gatherings to engage the community members on issues of GBV.
- Development of a directory of organisations working on women's issues, GBV and HIV and AIDS in Botswana

Knowledge of the campaigns

The prevalence and attitude survey for this study asked women and men about their knowledge and participation in GBV campaigns.

Figure 7.1: Awareness of andparticipation in campaigns

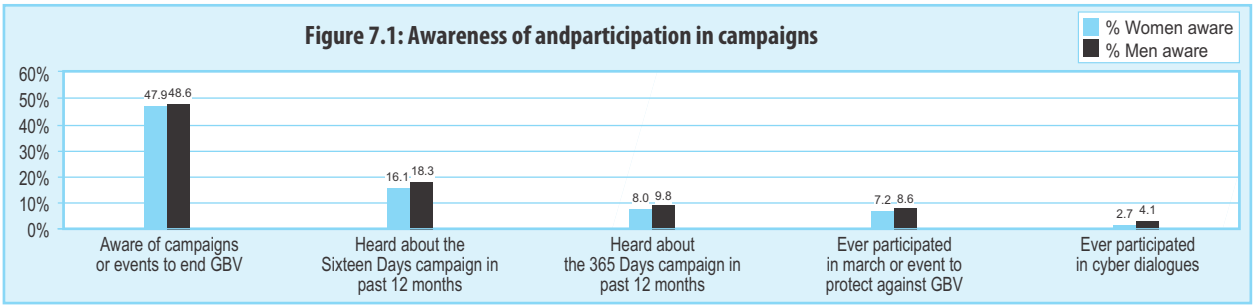


Figure 7.1 shows that almost half of the men and women interviewed knew of campaigns or events to end GBV. Less than a fifth of women and men interviewed had heard about the Sixteen Days campaign in the 12 months to the survey. Less than a tenth of women and men had heard of the 365 days campaign in a similar period. It is clear that awareness raising and regular monitoring and evaluation of GBV campaigns should be built into future GBV prevention strategies.

Source of information of events or GBV awareness campaigns

The survey asked participants who had heard about the campaigns about their source of information.

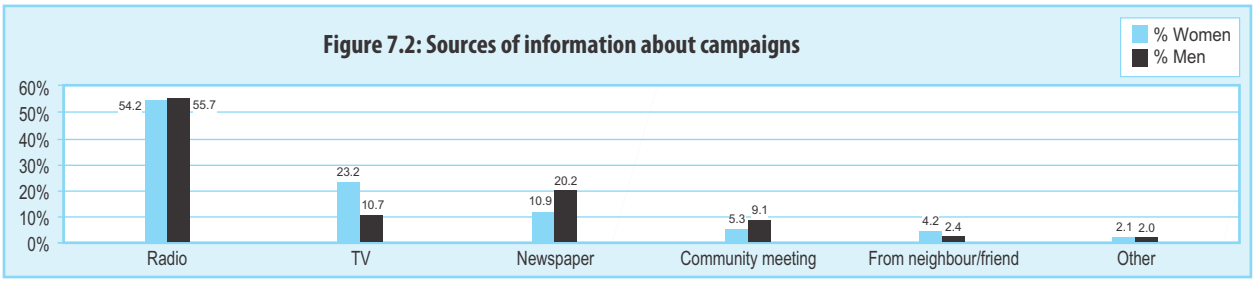


Figure 7.2 shows that the majority of people aware of the campaigns heard about them through radio. This is in line with the fact radio reaches the widest audience in Botswana.

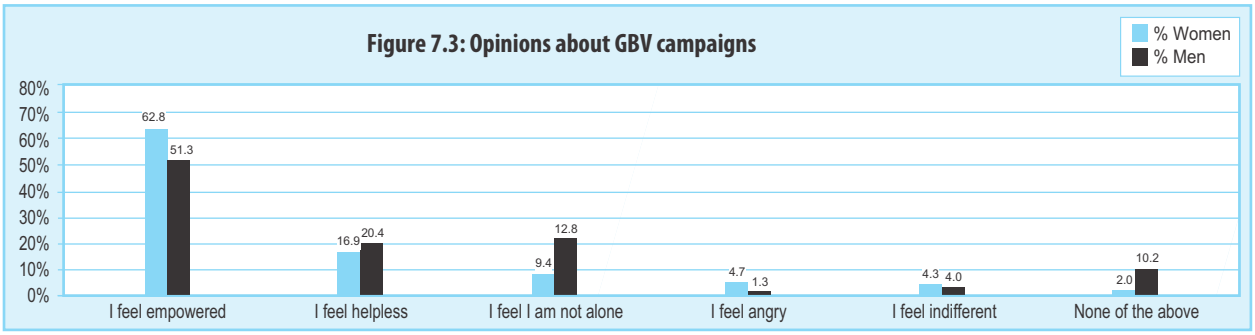


Figure 7.3 shows the opinions about GBV campaigns. The majority of respondents, especially women (63%), said that they felt empowered after learning about the campaigns. A smaller proportion of women said they felt helpless (17%) and 9% said it made them feel like they were not alone in having to deal with GBV.



March against GBV by FBOs organised by Women's Affairs Department during the Sixteen Days of Activism in Gaborone, Botswana. *Photo by WAD*

GBV and the media

As discussed in Chapter four on the drivers and causes of GBV, the media can either be part of the problem or of the solution in fighting GBV. The media is potentially a powerful tool in fighting GBV because it not only reports on society but helps shape public opinion and perceptions. The media calls attention to social issues and problems and it can hold leaders accountable. A number of NGOs work in the field of communication for social change. They have devised various strategies for influencing the media agenda on GBV. The *Gender and Media Progress Study* (GMPS) quoted in Chapter two showed that only 5% of the stories during the monitoring period focused on or mentioned GBV. Women constituted only 26% of news sources in the GBV category, despite women being the majority of those affected.

Coverage of GBV - what the statistics mean

The study conducted a qualitative analysis of media coverage in two newspapers to obtain an understanding of what these statistics mean, and how coverage of GBV can be improved.

Two of the news articles analysed came from Mmegi. *"Challenging masculinities to address sexual and gender based violence"* covered a programme aimed at sensitising boys and men to the challenges women face in the context of gender violence and HIV and AIDS.

The other story titled *"Marching against gender-based violence"* discusses plans by government and faith based organisations to march in protest to acts of GBV.

The articles chosen for analysis made passing reference to the causes of gender violence, citing unequal power relations and general inequality between men and women. The articles do not provide substantial information about the cause of the problem making it difficult to understand how the problem can be prevented in future. Neither of the articles mentioned the extent of gender violence, or provided statistics to support any of the information included in the article.

This is problematic because the reader is not given perspective on how prevalent (or not) GBV is. Regarding the effects of GBV, one story acknowledged the link between gender violence and HIV. It is important to acknowledge the ways in which sexual abuse and domestic violence can contribute to the spread of HIV and AIDS. This is because victims of GBV lose their power to negotiate for safe sex.

The articles did not elaborate on the various forms of GBV, with rape mentioned once. They did not touch on psychological abuse, femicide, violence against men and attacks against homosexuals.

However, the stories do mention steps being taken to curb GBV, referring to multi-sectoral approaches between Botswana Police Service, the Health Ministry, civil society organisations, magistrate and customary courts. They also allude to the inclusion of young boys in a training programme aimed at transforming men from perpetrators to champions of ending gender violence.

Both articles made use of expert sources including professors and those working in the NGO sector. Unfortunately, neither of the articles included the voices of those directly affected by gender violence such as survivors or their relatives. This would greatly enhance the stories by adding the first hand views of someone who has experienced the issue being discussed.

GL also analysed two news articles from *Mid Week Sun:* one titled "Man slits girlfriend's throat, hangs self" and the other "Raped by own father".



Double tragedy for girl who was

Raped by own father

BY CALISTUS BOSALETSWE

A 61-year-old man is standing trial in Ramotswa after he allegedly pounced on his stepdaughter and forced her to have sex with him the whole night after she had been gang-raped by two young men earlier that night.

Bashi Ramaina is charged together with Bobo Refilwe Mokgadi, and Opelo Moeng – both aged 21 - who had previously gang raped the complainant (name withheld). The three men appeared before Ramotswa magistrate Thabo Malambane at the close of last week to answer to the charges.

The details of the sordid experience were revealed by a police investigating officer, Kedumetse Shamukuni, who explained how they were called to Ramaina's house on that fateful March 2008 night.

She said the complainant told the police that she had met Moeng and Mokgadi who grabbed and dragged her to a nearby bush where they allegedly assaulted her sexually.

The police officer said the complainant told them that after the rape she remained lying there when the two accused persons disappeared in the darkness.

Shamukuni told court that the complainant met double tragedy when she arrived at her stepfather's homestead. She said the complainant told her stepfather that she had been raped by two young men whereupon Ramaina offered her a bed to rest on. But during the night Ramaina allegedly crawled into his daughter's blankets and had sex with her the whole night.

When giving sworn evidence, Moeng and Mokgadi denied sexually abusing the complainant. They said they saw her with another man during that fateful night, adding that they never talked to her. They were astonished to hear the following day that they had raped her. They could not answer when the magistrate asked them why the complainant identified them as the ones who raped her.

When giving sworn evidence, the complainant's stepfather denied any knowledge of the incident. He further denied ever seing his stepdaughter on the date in question. When Malambane put it to him that his stepdaughter had informed the court that he had forcefully had sex with her the whole night he denied. Malambane has informed the accused to file a summary of evidence on September 16.

The selected articles report on gross criminal activities in which one woman was murdered by her boyfriend and another allegedly raped by her stepfather but fail to go beyond the event and so lack depth. For example, in discussing the woman's murder, the author could have shed more light on femicide, its causes and effects on communities and the economy.

Also, for the woman who was raped, the writer could have elaborated on the fact that the majority of acts of sexual abuse occur between people who know one other, not strangers. This would do much to address the misconception that rapes most frequently occur between strangers. These are small examples which show how a bit of research and willingness to be thorough can greatly strengthen stories about gender based violence. Instead, it was found that both articles lacked any information about gender violence, its causes, effects, prevention initiatives and support structures for survivors. This is of course a major problem because the media should strive to provide audiences with accurate and holistic information in order to challenge attitudes and perceptions about GBV.

None of the articles presented the views of experts of GBV or the victim or their relatives, greatly reducing the impact and depth of the story which could have benefitted from additional perspectives.

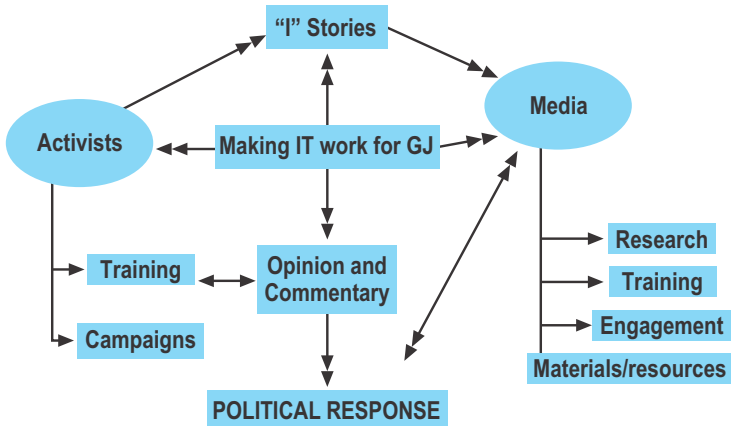
The articles highlight the key weaknesses of GBV coverage: that either the media covers this topic in sensational or superficial ways. During the consultative workshop on the findings of the GMPS, editors and journalists reported apathy in the reporting of GBV. The coverage tends to be sensationalistic and focused on unusual incidents, such as the case of the man who was stabbed by his lover. Such stories feature prominently on the front page and on posters to sell newspapers.

Participants called for in-depth rather than event-based coverage of GBV. This could be achieved through features and analysis. Lack of resources and specialised reporting were cited as some of the reasons why GBV receives little coverage.

Gender Links' GBV and media model is illustrated in the diagram. The key elements of GL's media strategy are as follows:

- Working directly with mainstream media through research, training, developing gender policies, continuous engagement: providing useful links and contacts.
- Working with gender activists to develop strategic communication skills and package their issues more effectively to ensure media coverage.
- Linking activists and the mainstream media through the Opinion and Commentary Service: In particular, GL works with survivors of gender violence to tell their stories, providing content that is often difficult for the media to access due to lack of trust, time and skills constraints.
- Using IT to maximise impact, build skills and capacity.

GL media and GBV Model

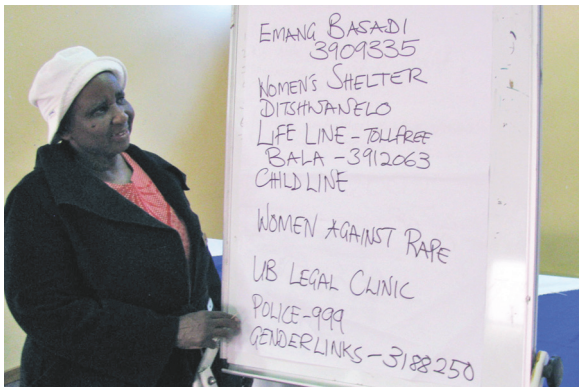


GL has recently embarked on a campaign to enlist media houses in the region as Centres of Excellence for Gender in the Media, including six media houses in Botswana: Gabs FM, Echo, Yarona FM, The Voice, Mmegi, Sunday Standard and Duma. The programme is part of a concerted campaign to support media houses in the development and implementation of gender policies, that include regular monitoring of media content. Coverage of GBV is an important focus of this programme. Continuous monitoring will assist experienced trainers in providing practical support to media houses in improving the quantity and quality of coverage.

Local government action plans for preventing gender violence

The UN Secretary General's report on gender violence calls on states to build and sustain strong multi-sectorial strategies, coordinated nationally and locally. Following the workshops on mainstreaming Gender in Local Government in the different local authorities across Botswana, GL conducted GBV action plan workshops to ensure local action to reduce gender violence. Working in partnership with the Botswana Local Government Association (BALA) GL Botswana developed district level action plans to end GBV in the ten district councils of Botswana.

Altogether Botswana has 35 councils (10 district councils, six urban councils and 19 sub-district councils). GL is currently working with 18 councils from the 35 local authorities (Ghanzi, Maun, North East, South East, Gaborone, Kgatleng, Selebi Phikwe, Moshupha, Letlhakeng, Mogoditshane, Molepolole, Jwaneng, Mabutshane, Chobe, Francistown, Sowa, Kgalagadi and Lobatse).These councils have elected to join the Centres of Excellence (COE) programme. GL seeks to expand the initial 18 COE's to 35 by 2015.



Mma Matshameko, Projects Manager at BALA, facilitating a session on GBV services in the Kgalagadi Council. *Photo by Vincent Galatlhwe*

In a key next step to this project, GL, BALA and WAD aim to decentralise the GBV indicators study to local level with the aim of establishing the extent, underlying factors, effects, response, support and prevention of GBV in the COE localities. At local government level, the project will create a concrete link between national policy initiatives and the practical implementation of strategies to address GBV in communities. The project will build on several years' work on gender and local government to challenge the prevailing assumption that GBV is not a local level competence.

The partners propose to collect more in-depth information on the extent of GBV at community level by increasing the number of participants to 400 sampled per locality. Adapting the indicators methodology at local level will allow for more detailed baselines on attitudes and all forms of violence at community level. This will enable GL, WAD and BALA to measure and make conclusions about GBV in a particular locality. Comparisons can then be made between local and national statistics to gauge where the council stands on GBV relative to the rest of the country.

The research findings will be used to inform prevention campaigns and programmes being implemented at local level. Through the strategic communications training and implementation of reviewed action plans informed by the local research findings, GL hopes to demonstrate that the fight against GBV can be won, through targeted, concerted prevention campaigns that seek to reclaim societies, community by community. The Kgatleng Council example provides an insight into the potential for working with local government to win the war against gender violence - community by community.

Kgatleng Council campaigns against child abuse
At the 2011 Gender Justice and Local Government Summit and Awards Dineo Segobai from Kgatleng District Council, Botswana accepted the prize in the response category for a relevant project championed by the council.



Dineo Segobai from Kgatleng District Council, Botswana.
Photo by Colleen Lowe Morna

Located in South East Botswana, 44 km from the capital city Gaberone, Kgatleng is the smallest district with a population of about 73032 (35734 males and 37773 females). Kgatleng has 73497 households and 51.3% of them are female headed. The HIV and AIDS pandemic has had a disproportionate effect on women.

The Kgatleng District Council identified the need to raise awareness and provide a response to cases of child abuse including incest and defilement. Concerns include the physiological effects of child abuse on the child and the fact that most offenders are former child abuse victims. The programme includes awareness campaigns, providing referral systems and conducting workshops that focus on children, parents, and the community as a whole.

Key partners in this initiative include the Department of social services, UNICEF, PEPFAR, Mark' n Ark Trust, government departments, Gender Links and BALA.

Key results include:
- Levels of abuse have dropped;
- Perpetrators are coming forth and are assisted,
- Child-to-child counselling and support has improved among victims,
- More support groups have been formed and are functioning,
- The relationship between HIV AIDS infections, orphan hood and gender based violence has been well defined,
- More orphans whose parents died from HIV and AIDS now know their status and access relevant help.
- Good networking and timely referral among service providers who annually commemorate the *Sixteen Days* of Activism.

Secondary prevention

The aim is to deal with the short term consequences of abuse that has occurred including:
- Empowering those charged with the responsibility of addressing GBV with the skills to promote prevention and the ability to deal sensitively with the survivors.
- Strategies include training key stakeholders: police; health personnel; traditional leaders; prosecutors and faith-based organisations.

Training police

WAD continues to work with the Botswana Police Service in an effort to empower law enforcement officers to be diligent in handling GBV cases and to enhance their sensitivity to such cases. The Department has worked with the Police in the process of establishing the Police Gender Focal Points programme.

The Department ran a series of training in 2010 and 2011 with 164 police officers. These officers have now

been appointed as Gender Focal Persons (GFPs) within their respective police stations and each of the 78 stations in the country now has 2 GFPs. In addition each of the 15 Police Districts now has a GFP trained to coordinate police stations in their district. The training included the development of a comprehensive reporting tool for use by the GFPs to capture and compile data on gender based violence.

There has been positive feedback in terms of efforts by Police GFPs to assist victims of GBV and to network with other community based structures and NGOs that work closely with the Police. Botswana Police Service continues to engage in community policing programmes and strategies to combat domestic violence through their Police Crime Prevention Unit.

Speaking out can set you free

An important dimension of secondary prevention is providing space for survivors and perpetrators of gender violence to speak out. In the course of this research, 25 women and 10 men wrote their stories.

The report bears testimony to these stories and excerpts. Facts and figures only tell a part of the story. The *"I" Stories* demonstrate the importance and value of those most affected being at the forefront of any GBV campaign. They receive media pick up; generate discussion and debate; and on the whole are empowering to the women concerned.



Tertiary prevention

Tertiary prevention focuses on long term interventions including perpetrator counselling. This is a relatively new area in Botswana. But the example of the work by WAR in Maun demonstrates the value of holistic long term approaches that include perpetrator counselling. This example also shows why it makes sense to cascade national plans to end violence to the local level, and to adopt the community-by-community approach.

WAR on violence in Maun



Women Against Rape (WAR) Coordinator Peggie Ramaphane, presented a best practice at the Gender Justice and Local Government Summit in 2011 on a community based programme to transform gender relations called SASA. The acronym comes from:

- Power within (start)
- Power over (awareness)
- Power with (support)
- Power to (action).

Education

WAR educates communities on gender-based violence and HIV and AIDS with the goal of creating long-term behavioural change, running programmes in schools, community programmes and through WAR Youth Clubs that apply fun peer-to-peer education techniques, such as dramas and poetry, to encourage students to live healthy lives.

Research and Advocacy

WAR collects client information to gain full understanding of the causes and effects of rape and other GBV. Information gathered is used to inform the organisation's programs and to stimulate legal reform, policy reform, and changes in processes and

practices. WAR advocates for disadvantaged groups in our communities and network with other service providers, locally, nationally, and internationally.

Economic Empowerment of Women
To reduce the economic dependency of survivors and potential victims of abuse, WAR provides access to skills training, business training, and marketing skills courses.

Perpetrator rehabilitation
As part of the activities to reduce GBV, WAR has begun to focus on perpetrators. WAR now contacts the perpetrator when clients report complaints and offers counselling and conflict resolution services. WAR also offers rehabilitation to convicts of sexual offenses. They help perpetrators gain insight into their behaviour and aim to correct it.

Achievements
Through its programmes, WAR has been able to:
- Map the community
- Undertake baseline surveys
- Build a partnership with the community and
- Increase its visibility.

Through their recognition that violence against women mitigates against women's full participation and integration in the development process of the country, WAR's programmes not only support survivors and perpetrators, but the prevention strategies aim to reduce all forms of GBV in the long run.
Source www.womenagainstrape.co.bw



"A real man protects his family" March against GBV organised by the Women's Affairs Department during the 16 Commemoration in Nata in 2010.
Photo by Vincent Galatlhwe

Conclusion

While there are several events and activities in Botswana relating to GBV, notably linked to the Sixteen Days of Activism campaign, these are not sustained throughout the year and they are not widely known. Political leaders mention GBV in passing. They have not put this campaign at the centre of national concerns in the same way as HIV and AIDS. Local level efforts to stretch the Sixteen Day campaign to 365 Days of Action to End GBV offer a sustained way of taking the GBV indicators study forward. Campaigns at the local level show that if the battle against GBV can be won - community by community - Botswana can be made safe for women. This requires leadership from the front, as well as a well articulated and integrated strategy for reducing GBV in the coming years. Prevention needs to be at the centre, not at the tail end, of such strategies.

CHAPTER 8
Integrated approaches



Flasback: Botswana Gender Activist Emelda Molokomme and GL manager Loveness Jambaya Nyakujarah, co- facilitate the Botswana GBV National Action Plan workshop, November 2007.
Photo by Colleen Lowe Morna

Key facts

- ✓ Botswana has a draft '365 Day National Action Plan to End Gender Violence' developed in 2007.
- ✓ The plan, reviewed in 2010 has no yet been adopted and hence there are no comprehensive budgetary allocations for its implementation.
- ✓ There are however notable achievements by government and civil society in the implementation of some of the actions prescribed in the NAP.
- ✓ Botswana has made significant progress on HIV and AIDS. The HIV and AIDS plans and strategies provide important lessons for GBV.



"My name is Tshego[41] originally from Mogonye village, a woman of 39 with two girl children aged 20 and 16 years respectively.

I was working in Maun in 2007 I met a 30 years old man. We fell in love. He was very abusive. He forced me to have sex with him. He would go out with girls whenever he wanted. He played loud music till morning when I was on the night shift.

My problem is that I am afraid to leave him because he is always threatening me and is not afraid of the police. I suspect he is using dagga, he is always drunk. He does not want to see me happy. During one of my pregnancies, he kicked me on the tummy and asked why I was crying.

Every time I call the police for him he asks for my forgiveness. I agree hoping that he will change for the better. I have sought help from the police, tribal administration and District Commissioner's Office who warned him and the last warning he got was that from the Customary Court. After the warning he still abuses me. I had to move to Francistown for my safety. He is accusing me of dragging his name in mud as everyone in Maun now knows him for his abusive behaviour.

I have now taken it upon myself to part ways with him. He is younger than me and not even working now. I would like to forget about him and hope he stops threatening me. I understand he is even boasting that I cannot leave him because he loves me. He tells people that I wasted his time and did not give him a child.

I am afraid of him and his behavior that is why I want to end the relationship. I am even scared to talk to him on the phone. I just want to leave Maun and be on my own so I can think clearly. I trust in God that everything will be fine."

Tshegos story illustrates the multiple strategies required to assist GBV survivors and effective referrals from one structure to another. This chapter examines the objectives of the Draft Botswana National Action Plan to End Gender violence, a comprehensive, holistic plan to end GBV. The chapter includes a case study of the Botswana HIV and AIDS strategy to strengthen the argument for a strong, multi-sector action plan to end GBV.

National Action Plan to End Gender Violence

The draft Botswana National Action Plan to End Gender Violence is a response to the call by the UN Secretary General, in his 2006 global report on violence against women and children, for all countries to develop comprehensive, multi-sector plans to end this scourge. Developed on the eve of the Sixteen Days of Activism on Gender Violence in 2007, the plan is structured according to the 1998 Addendum to the SADC Declaration on Gender and Development for the Eradication of Violence Against Women and Children later incorporated into the SADC Protocol on Gender and Development adopted in 2008. These constitute international benchmarks for combating GBV at national level.

[41] Not her real name.

Strategic objectives

The overall objective of the draft National Action Plan is to provide a comprehensive, coordinated framework for ending gender violence, by stretching the annual Sixteen Days of Activism campaign into a 365-day campaign with measurable targets and indicators. Specific objectives include to:

Legal

1. To publicise the fact that discrimination based on sex is unconstitutional.
2. Review provisions in the penal code that have proved to be a stumbling block in addressing GBV.
3. To ensure that the Domestic Violence Bill, a private members bill is passed, supported by the executive and enforced.
4. To increase the rate of reporting cases of GBV.

Services

1. Establish the status of services available to victims and survivors of gender violence.
2. Conduct a needs assessment of services for all districts in Botswana.
3. Provide information on existing services to communities.

Education and awareness

1. Strengthen gender sensitive training, education and awareness raising to win allies and friends (strategic partners) to end GBV.
2. Create a comprehensive and deeper understanding of causes and consequences of GBV targeted participatory learner centred training programmes and tailored messages for different groups, including in school and out of school youth, men, parents, officers in the different institutions.
3. Empower women and men, girls and boys in self-awareness for self-management skills to prevent and respond effectively to GBV at all levels.
4. Undertake and share research and statistics and best practices at national, regional and international levels to eradicate GBV.

Social, economic, cultural and political

1. To establish the economic cost of GBV.
2. To create transformational change through targeted programmes for political, traditional, religious leadership and affirm positive tenants of culture to end GBV.
3. To empower women survivors of GBV and women in general with start-up capital and business skills.



Delegates discuss the Botswana GBV National Action Plan.
Photo by Colleen Lowe Morna

Integrated approaches; budgetary allocations; monitoring and evaluation

1. Ensure the best services for the client through a well-coordinated and structured system.
2. Ensure that the plan is well resourced, implemented and sustained.
3. Measure progress; take corrective measures; ensure that the objectives of the plan are being achieved.

Key implementing partners

- Women's Affairs Department.
- Gender Links.
- Police (GFP, Women Police Network, Crime Prevention Unit).
- Department of Social Services (Social and Community Development).
- Ministry of Health (Public Health and Clinical Services Departments).
- Ministry of Education.

- Administration of Justice.
- Customary Courts.
- Botswana Council of Churches.
- NGOs.
- Gender Committees.
- Local Authorities (Councils through BALA).

Evaluation of implementation

GL with support from UN Trust Fund convened a meeting to assess the progress made in implementing the National Action Plans to End Gender Based Violence (GBV) in the SADC region from 16-17 February 2011. This provided an opportunity for countries to take stock of where they are now and what still needs to be done and devise ways forward and get a regional overview. Each country was asked to identify their key achievements and challenges in the implementation of the NAPs. Emphasis was placed on devising a strong monitoring and evaluation process learning from the GBV indicators pilot project as a possible model.

Achievements

Key achievements made by Botswana in implementing a multi-sector approach and co-ordinated response to ending GBV include:

- The commencement of a process to develop a Referral System between key service providers of GBV and HIV and AIDS services as a component of the integrated approach to combating GBV.A baseline study was conducted to support the process of establishing the GBV referral system.
- Ministry of Health's development of the Framework for the Health Sector's Response to GBV (including Service Standards for Prevention and Management of Gender Based Violence for Health Care Providers) supported by UNFPA.
- Ongoing process to develop the Sexual Abuse Strategy that has a protocol on reporting child sexual abuse led by Department of Social Services.
- Establishment of Gender Committees at district/ community level - a structure responsible for community mobilization on gender and development issues, including raising awareness on GBV, hosting Sixteen Days and IWD Campaigns.
- Enhancing the sensitivity of the Police service towards addressing GBV through the establishment of Gender Focal Points in Police station, 154 police officers were trained.
- Community Policing programmes & strategies to combat Domestic Violence led by the Police Crime Prevention Unit and the Women Police Network.
- Government's continued support to organisations that provide psychosocial support and places of safety for survivors of GBV.
- Continued dissemination of the Domestic Violence Act 2008 through production and distribution of IEC materials and by addressing meetings, workshops and community gatherings.
- Continued sensitisation and awareness raising on GBV through campaigns during the Sixteen Days of Activism Against Gender Based Violence distribution of IEC materials.
- Increased stakeholder participation in the Sixteen Days campaign and extending of these activities through-out the year.
- The 2010 Sixteen Days Campaign was merged with the launch of Africa Unite Campaign.
- Continued provision of counselling, shelter services and legal aid by NGOs.
- Economic empowerment programmes by government and NGOs through skills development.

Challenges

The main challenge in the implementation of the NAP is that it has not yet been adopted and hence there have been no budgetary allocations for it. The result is that much of the actions are implemented by departments and organisations outside the NAP frame work. The Ministry of Labour and Home Affairs intends to shortly engage stakeholders in the review and adoption of the 365-Day National Action Plan to Combat GBV.

Smart partnerships

The Government of Botswana continues to engage with and identify strategic partners in the efforts to address GBV. Some initiatives include:

- Continued establishment of Gender Committees at district and community level - a structure responsible for community mobilization on gender related issues, particularly gender based violence.

- The Department continues to engage with community leaders (Chiefs, Councillors, etc.) to sensitise them on gender and GBV issues and collaborate with them on community outreach activities.
- Government continues to support organizations that provide psychosocial support and places of safety for survivors of GBV.
- Formation of strategic partnerships with religious structures in campaigning against GBV, particularly to reach the church community, continues. The Women's Affairs Department conducted a seminar for faith based organizations (FBOs) in September 2011 under the theme **'End It Now'** *(per courtesy of the Botswana Union of the Seventh Day Adventist Church)* to facilitate the FBOs to develop resolutions and strategies to combat GBV. The FBO umbrella structures will facilitate the cascading of the resolutions on ending GBV to their church members.
- Mobilisation of men on issues of GBV through collaboration with structures such as the HIV and AIDS Men Sector.
- Mobilisation of women on women and gender issues in relation to HIV and AIDS through the HIV and AIDS Women Sector.
- Guidance and counseling services at schools to provide support for children in need and for referral to relevant service providers.
- The government has also initiated economic empowerment programmes for women to support their economic independence.

Learning from what works

Several references have been made throughout the report to Botswana's HIV and AIDS strategy as a successful political response and integrated strategy for addressing a social pandemic. The parallels between this campaign and the need to declare a state of emergency in the fight against GBV need little elaboration. What is important is to analyse the strategies that have been employed in the fight against HIV and AIDS, and reflect on how these can be applied to end GBV.

Case study: Botswana's HIV and AIDS strategy

Botswana along with 189 countries adopted the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Declaration of Commitment on HIV and AIDSin 2001. The Declaration reflects global consensus on a comprehensive framework to achieve the Millennium Development target of halting and beginning to reverse the spread of the HIV and AIDS epidemic by 2015. Under the terms of the Declaration, success in national HIV and AIDS responses is measured by the achievement of concrete, time-bound targets that call for careful monitoring of progress in implementing commitments.

Botswana is one of the nine Southern African countries that continue to bear the global burden of HIV and AIDS, with each country having an adult prevalence of more than 10 percent. The 2008 Botswana AIDS Impact Survey (BAIS) estimated that 17.6 percent of the population aged 18 months and above was HIV positive in that year.

Botswana established a National AIDS Coordinating Agency in 1999. The Botswana HIV and AIDS Response Information System (BHRIMS *(an agreed national monitoring and evaluation system)* was put in place in 2001. The first National Strategic Framework or NSF I *(an agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners)*, covered the period 2003-2009. Following an in-depth review of the NSF I, a second National Strategic Framework (2010-2016) was approved in December 2009.

Several policies, plans and legislative pieces have also been developed to support the national response. For the current reporting period these include:

- The National Operational Plan for Scaling-up Prevention (2008);
- The National HIV Treatment Guidelines published by the Ministry of Health in 2008;
- The new National Guidelines for HIV Testing and Counselling, published by the Ministry of Health in 2009;

- The Public Service Act of 2008 which prohibits discrimination or prejudice of employees because of an HIV positive status;
- The Domestic Violence Act; No. 10 of 2008 which provides survivors of domestic violence with protection. In the context of HIV and AIDS this Act is important for removing barriers to accessing HIV prevention, treatment, care and support services for women and girls;
- The Children's Act of 2009 provides, among other things, guidelines for the provision of care and support for orphans and other vulnerable children;
- The Child Sexual Abuse Communication Strategy 2010-2014.

This supportive policy and legislative environment reflects the consistent commitment of the political leadership on HIV and AIDS which has prevailed since the epidemic was declared a national emergency. The top political leadership, for example, has consistently spoken out and supported the national HIV and AIDS response at the highest level.

Key strategies

- ***A holistic multi-sectoral national response to manage HIV and AIDS:*** Botswana is currently implementing it's second NSF. The NSF developed through a consultative and inclusive process that involved several consultations including a central-level workshop through which senior representatives from government, civil society, the private sector, religious organisations and development partners had an opportunity to evaluate and agree on emerging priority areas and lay the foundation for further consultations. Additionally four local-level consultative workshops for district stakeholders were held in the four major centres of Gaborone, Francistown, Ghanzi and Maun. Consultative meetings were also held with specific groups such as Youth; the Media; Organised Labour; monitoring and evaluation and research practitioners; private sector; and civil society. Like its predecessor, the NSF II also views HIV and AIDS as a complex and multi-dimensional problem that require a multisectoral national response.

- ***Coordination:*** The National Aid Coordinating Agency, a multi-sectoral coordinating structure, conducts joint planning and review and takes responsibility for the implementation of the NSF II.

- ***Political will and leadership:*** The NSF II enjoys the highest level of support from the Botswana government. The National AIDS Council is chaired by former president, Hon Festus Mogae. HE President Seretse Khama Ian Khama has made many public statements clearly demonstrating national commitment on HIV and AIDS. For example in his 2011 State of the Nation address. President Khama stated:

"Madam Speaker, access to ART treatment now has coverage of 95% of those eligible for treatment. A total of 194 clinics are now dispensing antiretroviral medicines. This has ensured that more Batswana can now lead longer and healthier lives, with life expectancy for people living with the virus having improved from 45 years in 2001 to 65 years in 2010.

Having reduced mother to child transmission of HIV to less than 4%, with recent quarterly reductions of as low as 2%, we are now working to achieve less than 1% transmission through the roll out of triple prophylaxis in all Districts and targeted outreach specific groups such as people living with disabilities and remote area dwellers. We however continue to face challenges of 'repeated pregnancies' among HIV positive women.

Here let me note that such progress as we have achieved in meeting the challenge of HIV and AIDS has come at a heavy, in the long-term unsustainable, price. Notwithstanding the welcome support we receive from international partners, it should be understood that about 80% of the financial resources devoted to HIV and AIDS are from the Government. In this context new HIV infections remain a serious challenge and hence prevention remains our priority. We are also concerned about an increase in the

number of TB-HIV co-infections in the country. This has necessitated the development of TB/HIV policy guidelines to improve treatment through intensified case findings and improved infection control."

- ***Resources and infrastructure:*** The Botswana Government provides 80% of the budget required to manage HIV and AIDS. The allocations have increased from USD 69.8 million to USD 348.2 million in 2010. The Government of Botswana has recognised that managing HIV and AIDS is critical for Botswana's national growth and development.

- ***Monitoring and evaluation:*** The Monitoring and Evaluation (M&E) of the national HIV and AIDS response in Botswana is carried out through the national M&E system known as the *Botswana HIV and AIDS Response Information System (BHRIMS)*. Established in 2001 BHRIMS has:
  - Developed an M&E system with defined national indicators aligned with global ones to guide regular data collection and reporting. The system has also achieved some level of harmonisation at district, national, regional and global levels. Accordingly, data collection tools have been developed and a system of data generation designed to yield requisite data at regular scheduled intervals.
  - Developed and implemented a national M&E training curriculum which has led to major improvement in both the quantity and quality of M&E expertise at different levels and sectors of the national response. This has in turn fed positively into the quality of M&E products such as reports and general practice, thus contributing significantly to the emergence of an M&E culture in the country.
  - Developed a M&E infrastructure. Heavy investment has been made in providing modern equipment required for a fully functional M&E system. This includes computers, projectors, internet service, and use of email for information sharing and dissemination.
  - Deployment of District M&E Officers has improved M&E capacity at this critical level of the national response. Together with M&E training, this has contributed immensely to the growth of M&E in Botswana.
  - Developed a national evaluation agenda guided by stakeholders priorities as a strategy to deliver user-relevant information to promote utilisation of M&E products in programme management decision-making.
  - Developed a National M&E Framework for HIV Prevention.



Faith based organisations speaking out against GBV during a march organised by Women's Affairs Department during Sixteen Days of Activism. *Photo by WAD*

Conclusion

With a lifetime GBV prevalence rate for women of two thirds and close to 30% in the last year, GBV is a pandemic of monumental proportions in Botswana, akin to HIV and AIDS. GBV is killing women - literally and figuratively. Pandemics of such proportions require the kind of political response for which Botswana has won international acclaim in the campaign against HIV and AIDS. Significantly, WAD has scheduled a review of the draft National Action Plan for the second quarter of 2012, so that this report can be used to provide baseline data with which to set targets, indicators, time frames and a strong Monitoring and Evaluation framework. The required budgetary allocation needs to be made, primarily by the Government.

The partnership developed between a regional NGO and National Gender Machinery in drafting a plan and then stepping back to gather baseline data is a regional and international best practise. What is required now is to apply the findings from this study to a bold and strong action plan that will see the tide of GBV recede in Botswana, just as HIV is on the retreat.

CHAPTER 9

Conclusions and recommendations



Participants at a march against GBV organised by Women's Affairs Department during Sixteen Days of Activism in Gaborone, Botswana. *Photo by WAD*

Conclusions

The single most glaring finding of this study is that the prevalence of GBV reported in the survey is 24 times higher than that reported to the police. This shows that GBV is the most flagrant violation of human rights in Botswana at the present time; yet also one that is not being adequately addressed by the systems and structures in place for doing so. Specific conclusions drawn include:

Extent

- Emotional and economic IPV is very high in Botswana. Although the usual perception is that women suffer physical and sexual abuse, the findings from this study show that other forms of violence particularly emotional and economic are highly prevalent within the population. Emotional violence in this study is actually the most common form of GBV.
- Violence is cyclical. A key finding was that a considerable proportion of women have experienced more than one incident of violence. Women experience multiple forms of violence.
- Violence is also intergenerational occurring in a continuum from childhood to adulthood. A large proportion of women who experience violence and men who perpetrate violence experienced or witnessed violence in their childhood.

Drivers and patterns

- Most women and men in sample agreed that rape survivors usually want to be raped and should be blamed for their experiences. Communities hold conservative and negative attitudes towards rape and rape survivors.
- A complex set of factors drive the perpetration of GBV in Botswana. Alcohol use, drug use, child abuse, multiple sexual relationships, conservative community beliefs and values, and patriarchal gender attitudes are major drivers of the GBV pandemic in Botswana.

Effects

- There are major health effects associated with experience of GBV. Health effects include unplanned pregnancy, STIs, HIV and poor mental health.
- GBV in Botswana has micro and macro cost implications to the economy. Although this has not been quantified in this study the response to GBV in Botswana is necessary through financial, infrastructural and human resources inputs.
- Survivors face stigma associated with GBV experience. Strong patriarchal social and cultural values are evident in Botswana.

Response and support

- Botswana Police Services has made headway in putting in place systems for responding to GBV particularly through GBV focal point training and stationing of two focal points in each station. The police have made significant progress in terms of data collection and management through the use of manual registers in each station maintained by the GBV focal points.
- The categories used by the police for collecting data constitute an international best practise. However, police data does not include marital rape, as this is still not recognised in law.
- With a prevalence rate of nearly 30% over the last year (according the survey) Botswana had 204 938 women who experienced violence. Of these, only 1596, or 0.6% got relief through the courts. This means that men who perpetrate violence literally get away with it.
- WAD conducted a study on referral systems for GBV. The study found inadequate and fragmented services for survivors of GBV.
- While this study shows a high prevalence of GBV, the glaring gap is the lack of shelters for GBV survivors. There are just two shelters in the whole country, one in Maun and the other in Gaborone. Both shelters are run by NGOs. Police cite the lack of places of safety facilities as a contributing factor to the withdrawal of some cases. Women who are abused by partners have nowhere to turn to other than their matrimonial home to live with the perpetrator.
- Women in the sample experienced more emotional violence than any other form. There are very limited services for mental health needs.
- The findings from the study show that although women and men said they knew about protective laws they did not know about the specific provi-

sions. Not knowing about the specific provisions means that they cannot utlise the law effectively.
- Less than six percent of women and men said they had heard about the Domestic Violence Act and Penal code from the community meetings. The "kgotlas" provide an important platform to engage and disseminate information to communities.
- Although leaders acknowledge that support for survivors of violence is a state responsibility, there is still a wide gap between the services available and the need.

Prevention

- There are several prevention strategies in Botswana being implemented in the different arenas for action including school based programmes, media outreach, local government action plans and the community wide public awareness raising campaigns. Although these initiatives are being implemented, it is unclear whether they have been developed based on evidence.
- The campaigns are not specifically targeting the need to change gender attitudes in order to reduce GBV. Many of the findings in this research point to conservative and patriarchal value systems for women and men.

Integrated approaches

- With a lifetime prevalence rate of 67% (about one third over the last year) GBV is a pandemic of monumental proportions that requires urgent action and strong leadership similar to that shown in the fight against HIV and AIDS.
- The draft national multi-sector plan to end GBV is in draft form and has not been adopted by the Botswana Government.
- It is difficult to identify clear monitoring and evaluation strategies for GBV that measure impact. Monitoring and evaluation strategies must be built into all GBV strategies from inception. The GBV Indicators Botswana Study provides a baseline. Ongoing monitoring and evaluation strategies must flow from the findings.
- The study demonstrates the value of strong partnerships between civil society and governments. Smart partnerships have been at the heart of this research and should be carried forward into the next phase.

Recommendations

Integrated approaches, monitoring and evaluation

- It is time for a National Action Plan to End GBV in Botswana. The first step would be to get GBV recognised as a national emergency with a correspondingly high level of commitment. The 2007 draft action plan to end GBV, updated in 2010, needs to be adopted, budgeted and a national coordinating arrangement put in place.
- To measure progress, WAD and partners must repeat this study every three to five years. By establishing the extent of under-reporting to the police, this study underscores the importance of periodic standalone GBV surveys in measuring progress to reduce GBV in Botswana. The findings from the survey research show the merits of this method compared to reliance on routinely collected data. Survey methods are also more useful as they allow for more in depth understanding of the settings, patterns and effects of GBV.
- Monitoring and evaluation strategies must be built into the action plan from inception. The GBV Indicators Botswana Study provides a baseline. Ongoing monitoring evaluation strategies must flow from the findings.
- There is need for a national GBV database in which all data from departments and organisations is centrally located. Statistics Botswana could, for instance, maintain the database. Departments and organisations would then be obliged to provide statistics on a regular basis firstly maybe on a quarterly basis. Once the database is running the reporting could be more regular so that at any given time the prevailing extent and status of GBV can be easily accessed. Data from the national database could be used to inform decisions and policy on GBV. This is critical for successful GBV programming informed by evidence. The requirement for all service providers to provide statistics will also allow for greater accountability within the sectors. Other African countries statistics' bureaux have worked with UNStatistics on initiatives to develop such

centralised databases. The Botswana Government and Statistics Botswana could pursue this initiative with the technical expertise from UNStatistics and UNECA.

Prevention and local level action

- As in the case of HIV and AIDS, prevention campaigns must be central to a strategy to end GBV and implemented with measurable targets, indicators and a monitoring and evaluation plan.
- A nexus should be found for HIV and GBV prevention campaigns, especially messages aimed at reducing multiple sexual relationships.
- All GBV prevention campaigns should place at their centre the changing of societal norms and gender attitudes.
- Concerted campaigns also need to take place in workplaces and schools since many women in the sample experienced sexual harassment in these sites.
- Prevention messages should target younger women and men because of the increased risk shown in this study.
- Further analysis is critical to understand the impact of each of the identified factors and how they interact in models for risk factor analysis.
- Rehabilitation of abused children especially boys is critical in the fight against GBV in Botswana.
- Efforts by WAD, BALA and GL to develop Centres of Excellence for mainstreaming gender should be strengthened by cascading the research to the local level, and using this data to strengthen local action plans for ending GBV. The war can be won - community by community!

Response and support

- The police should move from manual registers to an automated data entry and management system that is accessible to focal points from all police stations.
- Station commanders should undergo GBV training so that they can support the gender focal points.
- More financial resources should be allocated for vehicles and office space. These spaces should be victim friendly.
- More officers should be trained as GBV focal points to ensure the service is available 24 hours in police stations.
- The police should publicise the annual GBV statistics widely for the purposes of informing the public and decision-makers on the extent of violence reported.
- There is need for better management of data by GBV service providers for example the Health sector,



Meeting with local community in New Xade, Ghanzi District Botswana. *Photo: Roos van Dorp*

district commissioners, social services, magistrates' courts, and other NGOs. GBV service providers need to improve on the documentation of GBV cases dealt with. A decentralised and automated system for GBV surveillance is required. These changes will not only be useful to give routinely collected statistics but will also allow for internal programme evaluation.

- Provision of increased mental health services is critical. The health sector should prioritise the provision of mental health and counselling services as a means of responding to GBV. While the policy guidelines place an emphasis on dealing with sexual assault similar emphasis should be directed towards mental health effects.
- There is need for the development and institutionalisation of a clear referral system for GBV service providers. A clear and effective referral system is critical in reducing the possibility of secondary victimisation and in ensuring that survivors access all the GBV services they need.
- Government should make provisions for facilities of protection as specified in the Domestic Violence Act. The government needs to allocate resources for the running of existing shelters and for the establishment of more facilities.
- Campaigns and IEC material needs to be developed to inform the populace about the laws in detail. People need to be informed on the processes of how they access justice and their role in its administration.
- Community meetings and *kgotlas* should be used as awareness raising and information dissemination points for GBV.

Further research and sharing of this model

- In addition to repeating this study every three to five years, the indicators need to be expanded through a fully-fledged dedicated study on the economic impacts of GBV on the society.
- The smart partnership between a regional NGO with a national office and the National Gender Machinery in Botswana, as well as donors and inter governmental agencies, is a regional and international best practise. The partners in this project stand ready to share their experience with governments and stakeholders seeking strategic ways to reach the regional goal of halving gender violence by 2015.

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GBV AND THE SADC PROTOCOL ON GENDER AND DEVELOPMENT

Response and support

The SADC Protocol provides that by 2015 state parties shall:

- Enact and enforce legislation prohibiting all forms of gender-based violence;
- Ensure that laws on gender-based violence provide for the comprehensive testing, treatment and care of survivors of sexual assault;
- Review and reform their criminal laws and procedures applicable to cases of sexual offences and gender-based violence;
- Enact and adopt specific legislative provisions to prevent human trafficking and provide holistic services to the victims, with the aim of re-integrating them into society;
- Enact legislative provisions, and adopt and implement policies, strategies and programmes which define and prohibit sexual harassment in all spheres, and provide deterrent sanctions for perpetrators of sexual harassment.

Prevention

- The Protocol provides for measures, including legislation, to discourage traditional and cultural practices that exacerbate gender-based violence and to mount public campaigns against these.

Integrated approaches

- The SADC Protocol on Gender and Development calls on states to adopt integrated approaches, including institutional cross sector structures.

The ultimate goal....

- To reduce current levels of gender-based violence by 2015.

Ministry of Labour & Home Affairs

Women's Affairs Department

gender links for equality and justice

UKaid from the Department for International Development

UNFPA

FORUM FOR WOMEN AND DEVELOPMENT
FORUM FOR KVINNER OG UTVIKLINGSSPØRSMÅL
FOKUS

United Nations Development Fund for Women
UNIFEM

UNDP

"One of the most shocking statistics in this report is that the prevalence rate, as established through the first ever GBV prevalence and attitude survey, *is 24 times higher than the number of cases reported to the Police over the last year!* Successful conviction rate of GBV cases viewed against this overall figure is less than one percent (1%) of GBV experienced.

Clearly, there is a crisis of confidence. Women are not engaging and so not enjoying the full benefit of the very systems that are supposed to offer them redress. As the former Police Commissioner and Acting Minister of Defence, Justice and Security, I am deeply saddened by these findings."

Honourable Edwin Jenamiso Batshu, Minister of Labour and Home Affairs



www.genderlinks.org.za